MEETING

STATE OF CALIFORNIA

PUBLIC EMPLOYEES' RETIREMENT SYSTEM

BOARD OF ADMINISTRATION

PENSION & HEALTH BENEFITS COMMITTEE

OPEN SESSION

CALIFORNIA PUBLIC EMPLOYEES' RETIREMENT SYSTEM

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APPEARANCES

COMMITTEE MEMBERS:

Ramón Rubalcava, Chair

Kevin Palkki, Vice Chair

Malia Cohen, represented by Deborah Gallegos(Remote)

David Miller

Eraina Ortega

Jose Luis Pacheco

Theresa Taylor

Yvonne Walker

Mullissa Willette

BOARD MEMBERS:

Fiona Ma, represented by Frank Ruffino

Lisa Middleton

STAFF:

Marcie Frost, Chief Executive Officer

Matthew Jacobs, General Counsel

Kim Malm, Deputy Executive Officer

Donald Moulds, PhD, Chief Health Director

Rob Jarzombek, Chief, Health Plan Research & Administration

Julia Logan, MD, Chief Clinical Director

APPEARANCES CONTINUED

ALSO PRESENT:

J.J. Jelincic, Retired Public Employees Association

Dr. Todd May, Health Net

Brian Ternan, Health Net

INDEX

PROCEEDINGS

CHAIR RUBALCAVA: Good morning, everybody. I'm calling to order the Pension and Health Benefits Committee. And the first order of business is roll call, please

BOARD CLERK ANDERSON: Ramón Rubalcava.

CHAIR RUBALCAVA: Present.

BOARD CLERK ANDERSON: Kevin Palkki.

VICE CHAIR PALKKI: Good morning.

BOARD CLERK ANDERSON: 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.

COMMITTEE MEMBER WALKER: Here.

BOARD CLERK ANDERSON: Mullissa Willette.

COMMITTEE MEMBER WILLETTE: Here.

CHAIR RUBALCAVA: Thank you.

Now, we'll proceed to the health plan spotlight, the health presentations, and Don Moulds, if you could please do the introductions.

CHIEF HEALTH DIRECTOR MOULDS: Great. Thank you. Good morning, Mr. Chair and members of the Committee. Don Moulds, CalPERS team member. First off today, we have a health plan spotlight with Health Net. As you know, Health Net administers the Salud y Más health plan for CalPERS. Representing Health Net is their President and Chief Executive Officer Brian Ternan and Vice President and Medical Director Dr. Toddy May.

I'll go ahead and turn over to Brian and Todd.

BRIAN TERNAN: Okay. Good morning.

CHAIR RUBALCAVA: Good morning.

BRIAN TERNAN: As was said, my name is Brian Ternan. I'm the CEO and President for Health Net and with me is Dr. Todd May, who's the Chief Medical Officer for our commercial business.

(Slide presentation).

BRIAN TERNAN: And first of all, thank you very much for having us here today. We really appreciate the opportunity and we really appreciate our relationship with CalPERS.

During the presentation today, I'll give a little background on Health Net and then Dr. May will talk about

our clinical highlights that are key to our strategic plan.

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BRIAN TERNAN: So on this slide, what I wanted to demonstrate was we know that CalPERS core value is to deliver health care that is sustainable, high quality, affordable and comprehensive. And as you can see here, I think our core valued are aligned. Health Net's mission is to make our communities healthier one person at a time. And overall, we're looking to drive better health outcomes at lower costs. We also spend a lot of time focused on the member experience to make sure that your members' interactions with the health care system go smoothly. So again, I think that we are very well aligned on this. We'll talk more about it. The product in particular that we offer to CalPERS is called Salud y Más and it's a unique product. We'll get into some of the specifics of that as we go along.

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BRIAN TERNAN: A little background on Health Net. I think a couple points on this slide. You know, first of all we were founded 45 years ago, so we have a long deep history here in California. And our primary focus, as

you'll see here, is government-sponsored health care. So our main line of business with 2.1 million members is Medi-Cal. We also have a very large Medicare presence and a very large marketplace presence with Covered California.

In addition to that, we have clients like the County of Santa Clara, San Francisco Health Service System. And so we're very proud to serve CalPERS alongside many of those other government-sponsored plans. You also see on this slide our HMO footprint in California. In purple is the footprint for our Salud y Más HMO that we offer to CalPERS. So that is the service area that we are talking about here.

What I point out is because of our large Medi-Cal presence, we really know how to serve a diverse membership and cater to their unique needs. As you all know that's a very challenging membership and we have grown up serving that membership and adapting how we do things in order to serve them well.

We're also a very strong partner with Covered California and I'd like to point out one of the things we're very appreciative of is the State entities working together to align their core quality objectives. So we appreciate the alignment between CalPERS, Covered California, and the DHCS Medi-Cal program.

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[SLIDE CHANGE]

BRIAN TERNAN: So we also understand that CalPERS has a strategic goal that includes affordability and access. Our approach to managing our network providers lines up with this goal as well. The key to our contracting approach is balancing unit cost with access and quality. So we do a constant review of appropriate providers for our Salud network, it is a tailored approach, which means we target and contract a subset of available providers, who meet the criteria of our tailored network and those criteria are specific cost targets and a focus on quality.

Salud is also a value-based network. And what that means is we monitor the providers to ensure they're meeting our quality requirements. When they're not, we work with those providers to improve their outcomes and get them back where they need to be from a quality perspective. And at the same time, we align our incentives and how we pay those providers to ensure they're providing the right performance.

Lastly, it's an integrated network. And what that means is our care coordinators work with our behavioral health providers and the medical providers to make sure that that person is getting what we call whole person care. You don't want to have those two separated.

You don't want to have one not knowing what's going on with the other. And so we work hard to make sure that that care is coordinated. This has been especially important during the pandemic and then after the pandemic as we've all seen the demand for behavioral health care increase significantly.

Next slide.

[SLIDE CHANGE]

BRIAN TERNAN: So specific to Salud y Más, this is again an offering -- this is the offering we provide for CalPERS. It is not a CalPERS-specific offering so we offer this to other employers in that service area. As a matter of fact, we have about 150 large group clients that offer Salud y Más and about 1,400 small group clients that offer Salud y Más. Of our 47,000 members in this product, CalPERS makes up about 25 percent of that membership. So you are not alone. It covers seven counties in Southern California and offers cross-border coverage in Mexico, which is really what makes it unique.

So again, knowing how much CalPERS values access, in order to be responsive to requests in 2022, we added the Scripps Medical Group in San Diego to this network. And in 2025, we expanded into Imperial County as a new service area. As I said, a unique feature of Salud y Más is the cross-border coverage. So I know that our team and

some of the CalPERS staff had a chance to tour the facilities earlier this month to see it firsthand. Our partner there is SIMNSA. And they have over 500 providers and a state-of-the-art hospital in Mexico. And so the way it work is all of our members, your members, are assigned to a medical group and a primary care doctor in California and then they have the added option of accessing SIMNSA south of the border. They cannot access it. Their dependents, who may live in Mexico, can access it. It's sort of an added benefit. It's paid on a fee-for-service basis and comes directly to us for payment from SIMNSA.

So, this is also a product that because of the uniqueness of it and having that cross-border option, I think it really allows us to focus on health equity and, in many ways, it cate -- it's catered to the Latino population. And so it gives us a real focus on that population and their needs.

So now, we're going to transition to Dr. May, who will talk about some of the clinical areas, including managing populations, health equity, data, and few other things.

DR. TODD MAY: Great. Good morning, everyone

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[SLIDE CHANGE]

DR. TODD MAY: I'm going to start with our

approach to population health management. Now, there's a lot on this slide and don't worry about details. I'll just walk through the roadmap of what this looks like.

So when we -- when we talk about population health management, we analyze the entire group of members and then we proactively identify their needs and then ensure that their needs are met across the spectrum and the stages of life. And that's the graphic in the center.

Turning to the graphic on the upper left, our health is very complicated. And it turns out that only about 20 percent of our health status is directly related to that health care we receive, while 80 percent of it is driven by what we call the social drivers of health. That's the influences of where we live, work and play, our individual life style behaviors, our access to education and our income, access to healthy nutritious foods, transportation, all of that. That's actually 80 percent of the factors that influence our health. So we identify those social drivers and mitigate them when we can.

Turning to the -- to the left corner, we talk about data. To understand our membership, we use data and predictive analytics to study our members, and then we devise and target our specific interventions, and then we measure. So data is key here. It's a big cycle and we'll talk more about data.

And across the bottom, you'll see that we have a robust menu of tools, and resources, and interventions to meet the needs of our members. And they're in various modalities. So members have a choice to -- you know, if it's digital that they like the best, if it's more of a personal touch, there are options to best meet their needs.

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[SLIDE CHANGE]

DR. TODD MAY: I'll talk about health equity. You know, it's very rewarding that finally health equity is getting the attention across the industry that it should. And this is not new for us at Health Net. We have deep roots in health equity. It's in our DNA. We've been doing this for decades. It's actually an important reason why I joined this company. In fact, Health Net is the only health plan in the country, in the country, to achieve the health equity accreditation plus status with NCQA across all lines of business in 2024.

And this is not our first recognition. We were the first health plan in the country to achieve the multicultural health care distinction by NCQA across all lines of business way back in 2011. Now, we have deep expertise in the core areas of promoting health equity, including language assistance, health literacy, cultural

competency, and addressing disparities in health care.

And equity is not just a department or a side project for us, we have a health equity strategic plan, and those core principles in that strategic plan are embedded in all we do across the company.

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[SLIDE CHANGE]

DR. TODD MAY: Now, let's talk about data. Data is the key driver for all improvement work. We have a fragmented health care system, and therefore, we have fragmented data. And accurate, actionable data is essential for our population health work, for our health equity work and for our quality improvement. And Health Net is investing a lot of resources and efforts in collecting, organizing and using data. We were one of the first plans to join health information exchanges and we are one of the most connected plans in the state.

Now, health information exchanges facilitate data sharing between hospitals, skilled nursing facilities, medical groups and health plans. And that -- when we have that data, we get a more full picture of the health status of our membership. Another key source of data is called ADT needs, admission, discharge and transfer. These are real-time alerts that we receive when our members land in an emergency department, or admitted to a hospital, or

when they're discharged. Now, these are key points so that we know what's happening with our members and we can facilitate a smooth transition back to primary care. And in the process, we seek to reduce unnecessary emergency department visits and readmissions to the hospital. And we are connected to literally hundreds of hospitals.

On the theme of data and its importance, we partnered -- Health Net has partnered with Covered California on an innovative data exchange project. And we co-presented at the NCQA Health Care Innovation Summit just a couple weeks ago. With Covered California, our members experience significant churn. The average time that members spend on any one given plan is about 14 months, so it's not very long. And when we -- when we look at important metrics like cancer screenings, there's a look-back period of two to ten years, depending on which cancer screening we're looking at.

But if we only have a one-year window, and that's all we know about a member, we don't know if they've had the necessary screenings previously or not. So we engage with Covered California, got a data exchange going, so that we could look at our members and see what they had done when they were with other plans. And through this, we improved the accuracy of our data. We decreased unnecessary testing and outreach to our members. That

reduced friction for our members and our providers when we're out there, you know, pestering them to go get tests that they actually didn't need because they had them two years ago, for example. And this just decrease costs. And then this allows us then to focus our resources on the members who need that attention the most.

That's what health equity is all about, when you get down to it, right?

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[SLIDE CHANGE]

DR. TODD MAY: I am very pleased to talk about two high profile statewide initiatives that are based on innovation and collaboration. Health Net is deeply engaged. I am personally deeply engaged with these products -- projects. Robust primary care is the foundation of high quality, cost effective and an efficient health care system. And when you have a high functioning primary care base, you can over -- reduce overall utilization and costs, increase the use of preventive services, and actually decrease disease burden and death rates. Super important. And I think we all know how stressed primary care is at this time.

Now Health Net is an active participant - I personally am involved in this - in the California Advanced Primary Care Initiative. This is an innovative

multi-player initiative, where we are coming together to work with mutual practices to help them transform the way they conduct business to become higher functioning, full wrap-around services for their members, taking a population health management approach, much like I explained earlier, rather than just seeing patients as they come and reacting to what they come with, being more proactive and manage their entire panel of patients.

There a three key components. First, we're paying the primary care practices more to invest in this work, actually transform their practices, and be more effective and efficient.

Second, we're providing technical support or coaching, teaching them how to transform their practice.

And three, we are rewarding the practices with incentives when they improve their outcomes by adopting the advanced primary care model. And we are very pleased that CalPERS is a valued supporter of this groundbreaking initiative.

Next, Health Net initiated and is leading an unprecedented multi-plan collaborative to promote and support quality improvement at hospitals that are underperforming. We, along with four other health plans now -- we started with two others. Now, we have a total of five. We engage with hospitals, encourage and support

them in their improvement work and hold them accountable for their performance. And we're getting attention by hospital leadership. We met with three hospitals just last week, two of those three hospitals brought their CEOs to the table illustrating how important this is. They're making commitments to improve.

And while the results vary a bit from metric to metric, we are seeing improvement across every hospital that we've engaged and we are expanding our engagement of hospitals over the next year. So we at Health Net are proud to lead this unprecedented innovative approach. I'm going to tell you I've never heard of anything like this, multiple health plans coming together meeting with hospitals and helping them improve.

You know, this is who we are at Health Net. You know, we are working on transforming health care for all Californians. We are innovative, we are collaborative, and this is the work that we do.

Thank you.

Brian, back to you.

BRIAN TERNAN: All right. That's all we had for today, so welcome to open it up to questions.

CHAIR RUBALCAVA: Well, thank you very much for an excellent presentation and again I want to thank you for what you bring to our members in Southern California,

particularly, you know, we always applaud value-based networks and health equity of course. And you have a unique plan. And again, I want to thank you for extending Salud y Más into Imperial County.

So now, we'll go with questions of the Committee.

No questions. So I guess -- we do. I'm sorry. We do have questions. Start with Mr. Palkki.

VICE CHAIR PALKKI: Thank you for the presentation. Just really quickly, you talked a little bit about the different sources of data where you're selecting. Do you see that process improving with sort of like if AI becomes more robust or in that area?

DR. TODD MAY: I mean, I think the -- so the first -- the first step, the essential step is mainly what I talked about, which is actually getting the data and aggregating it. And then the next step is what you do with it. And, you know, when you're getting big data, big data feeds, it's pretty sophisticated. We have -- we have sophisticated predictive analytics and models where we can really stratify our members and identify, you know, what levels of health status they have and then tailor the programs to meet their needs.

I think AI though has the potential certainly to be an even more powerful tool in really pinpointing down to a member level what -- where they stand and what their

needs are. And we talk about care gaps. That's where say their diabetes is not adequately controlled, or their blood pressure is not adequately controlled, or they haven't had the colon cancer screening. You know, the more we can just readily identify those gaps, then we can reach out to members and address those issues to again improve health outcomes.

So I think there is -- there is a lot of potential, particularly in -- particularly in the data. I mean, I think there's a lot of concern about AI and kind of the ways it might go askew, but I think with data, that's pretty solid.

BRIAN TERNAN: I might add one thing. If you think about our world with the challenges, as we're looking at data, we're identifying gaps. We're feeding them back to the providers to say this looks like something you need to address with your member. The worst thing that can happen is we're feeding a suggestion to a provider and they're saying I already did that or, you know, you're wrong, this isn't a gap, whatever it might be. So then you lose credibility and then they stop doing it.

So the precision I think will really be a big help, because when we're sending those recommendations, we'll have a lot more confidence that they actually needed

care.

DR. TODD MAY: Yeah, thank you for saying that. That's the point I was trying to make is I think it's a low risk, in the data area with AI. And to Brian's point, that's why I was talking so much about getting the data, the health information exchanges, the ADT feeds, because when we -- when we didn't see the full picture, we're sending information to our providers and saying, hey, we think there's a gap here. We think there's a gap here. And, you know, that annoys them. When it's like, no, we've got this taken care of. We took care of that a couple years ago, so that's why that's important.

VICE CHAIR PALKKI: Thank you for that. You also mentioned the stress on the primary care. Is that because of staffing levels, the shortage of staff or -- what are you guys seeing?

DR. TODD MAY: So I'm a practicing family physician. And so, I've practiced primary care for over 30 years. There are a lot of factors. And one, there are just too few primary care physicians. I mean, we have an inverted pyramid in this country. Most high-functioning health systems have a very strong foundation of primary care and relatively smaller specialty care and we're the opposite. So there just aren't enough primary care clinicians.

And then the expectations, the amount of work that is required to provide that full comprehensive primary care is extensive. I mean, the estimates are, you want to take -- if you were to do everything that was necessary, it would take you over 20 hours a day to actually complete those tasks, which is obviously not possible.

So there -- we need workforce development. We need higher pay to encourage medical students and residents to go into primary care. We need to diversify the workforce to match the diversity of our population. We need to pay them enough, and then give the resources. When we're talking about advanced primary care, that model is not just reliant on one primary care provider, but it's team based care. You have people doing -- contributing to the work at the level they're training and expertise. So there's a lot there in what's happening with primary care. That's a real quick summary.

VICE CHAIR PALKKI: Thank you. That's all my questions.

CHAIR RUBALCAVA: Thank you, Mr. Palkki.

Mr. Pacheco. Jose Luis Pacheco.

COMMITTEE MEMBER PACHECO: Yes. Thank you. Thank you, Chairman Rubalcava. And thank you, gentlemen, for your presentation. I really, really liked this

material, especially the Salud y Más in the Imperial -- down in the Southern California area, near Mexico.

I wanted to ask you a question about the whole person. I wanted to know if -- I was reading your material and I wanted to know if there's a component of cultural competency that you have with respect to your delivery of care? If you can elaborate more on that. I was -- I was -- it wasn't in the notes, but perhaps I think you may have that.

DR TODD MAY: Yeah. So that's really important. So we do tailor all of our materials, whether it's outreach to our members, it's educational materials, or individual outreach, we make sure that our folks are trained in cultural competency. Language access is really important to us. We provide free interpreter services to all of our members in dozens of languages. But we're very mindful of that aspect. And we have -- we have a very talented health equity team that goes through all of our materials, that goes through our scripts, that goes through -- you know, through how we interact with members, certainly, the latino population, but also all the other populations that we have in California.

COMMITTEE MEMBER PACHECO: That's wonderful. I would imagine in -- well, in San Jose for instance, which is one of the -- one of your serving providers, the County

of Santa Clara, one of the -- one of the other com -- other populations is the Vietnamese community, the Hmong community, and they have a very unique cultural competency area as well, which I recall. So there are so many other, other than Latino, which is really important.

I wanted to ask you just a question about -- it's kind of a follow-up with Mr. Palkki's, regarding the physicians and -- in terms of their -- how many physicians do you have that speak Spanish and how many -- and of those -- of those that have it, are there other mechanisms that you've -- you may have -- are developing or novel that could deliver the care, like for instance telemedicine and so forth, if you can elaborate on that?

DR. TODD MAY: Yeah, I don't have a number of the language proficiency of our -- of our provider workforce in all languages. I mean, it's really important. And, you know, one thing that we want to work on better is actually having that data --

COMMITTEE MEMBER PACHECO: Um-hmm.

DR. TODD MAY: -- because I'm going to be honest, we don't have great data on the language proficiency of our providers, nor posted adequately on our -- on our search sites, so that's an area of work for us to do.

We do provide a lot of telehealth access in both physical health and behavioral health. And we do have --

make sure that we have -- if we don't have linguistically concordant providers, that we ensure that we have well trained interpreters. I'm -- speaking of behavioral health, I mean, it's really interesting that, you know, with the -- with the pandemic, so much of health care went virtual, right, and telehealth just shot up. For physical health, it's largely come back.

You know, I know just my personal experience, during the peak of the pandemic, we were 90 percent virtual encounters with our -- with our patients and 10 percent in person. Now, it's flipped back pretty much. But interestingly, behavioral health, we're still seeing about 50 percent utilization of telehealth as a preferred option for members for a variety of reasons.

COMMITTEE MEMBER PACHECO: Interesting. This is fascinating. And just to follow up one more with regarding the developing the primary care physician. As you mentioned, you have -- you said you have very few primary care -- yourself, you're a family physician. What are your thoughts on how to recruit more people? And, I mean, I know a lot of these students -- medical students, from what I've read, they come with a lot of student debt and it's a -- it's a burden on them. Especially after they finish their residency programs, they still have it, and they're not getting the compensation necessary to

compensate for that. Are there any ideas that you have at Health Net and -- to resolve some of these issues?

DR. TODD MAY: Yeah. I mean, it's a big question. It's a big issue. I mean, it's not something I think a health plan can actually take on. It's much bigger than this. It really comes down to a health policy question and what are we going to prioritize as a society, as State, as a country in terms of our -- some parity in reimbursements. Maybe debt relief for folks who preferentially go into primary care, so we encourage more of that without it being a personal sacrifice for folks.

The training slots, you know, maybe reducing some of the specialty slots, so that folks don't just go into those, because they're higher paying, but it's like, well, actually there aren't so many. You're going to have to look at your other options, but that's -- this is -- this is big. This is a big health policy level where this needs to happen. It's not -- if things are just left in the status quo right now, people are going to go where they go.

COMMITTEE MEMBER PACHECO: Yeah, exactly.

BRIAN TERNAN: I would add one -- just one thing, Todd, is that, you're right, it's a huge issue. One of the things we have going on and we can provide more detail. I don't know how we're doing on time, but we have

a workforce initiative to try to get at this program. And we're not -- it's not going to solve for the whole state. But if you think about it, one of the things we're trying to do is go into communities and start identifying young people who might not typically even think about becoming a clinician. Get them early, who are these top STEM students, are they good at this, sharing with them this is an opportunity for you, finding spots in medical schools for them, leveraging the junior college system. You know, it's like you've got to really get in there early, because if we rely on the current pool of candidates moving their way up through the current system, we'll never catch up. So we've got to identify new populations of people that might be interested and just not even know that it's an option for them.

And then you also -- that also helps you solve a lot of the, you know, health equity issues, where you've got a larger pool of Latino physicians, a large pool of Black physicians, things like that. All those communities now are starting to -- we're starting to see more primary care docs from those communities.

COMMITTEE MEMBER PACHECO: That's excellent. Yeah, that would -- that would be wonderful if you could share some of that information.

BRIAN TERNAN: Okay.

COMMITTEE MEMBER PACHECO: I think it's an incredible -- it's an important -- an important point, especially the diversity of the population that we have in California and how it's just growing. So I feel it's an -- it's an important area for us. And I want to compliment you for your efforts in doing this, especially, sir, your being a physician, a family doctor, that is a -- that's a lot and I compliment you what you've done for that.

DR. TODD MAY: Thank you. Yeah, I'll also mention, before I joined Health Net, I was a professor of family medicine at UCSF for 22 years stationed at the San Francis General Hospital Campus --

COMMITTEE MEMBER PACHECO: Wow.

DR. TODD MAY: -- which is the training site for our residency program. So we were very focused on a diverse -- cultivating a diverse physician group going into primary care family medicine specifically. And we established years ago, and it's still ongoing, a pipeline program, much like Brian is talking about, bringing in high school students, primarily from underserved and minority populations, bringing them into the campus, bringing them into the clinics, exposing them, and not just to be physicians, but to -- you know, to nursing, to lab, to the various opportunities in health care because

there are rich opportunities for great careers for folks. And so we're exposing them early, bringing them in, and really trying to hit the pipeline.

I'll also just briefly mention I know -- I don't want to take too much time, but UC Davis is doing some incredible work along these lines and they have -- they are one of the top three medical schools now in the nation in the diversity of their medical school class. And they -- I won't go into the details, but it's a lot of this type of work of getting gut there and bringing folks into the profession, and we need that. We need a more diverse workforce.

I mean, for the latino population in California, 40 percent of Californians are Latino, six percent of physicians are Latino.

COMMITTEE MEMBER PACHECO: Wow.

DR. TODD MAY: This is -- this is what we're looking at here. So we have a lot of work to do in this area. This is a big interest of mine. I mean, again, there's not a lot that we can do from a health plan standpoint. It is a bigger picture, but I just wanted to share some of what is happening out there.

COMMITTEE MEMBER PACHECO: Thank you very much, sir, I -- again, I really appreciate your efforts and I did not know you went to -- you were a professor at UCSF.

I believe you also have a residency program at Natividad.

DR. TODD MAY: Well, that's where did my training.

COMMITTEE MEMBER PACHECO: And Natividad --

DR. TODD MAY: I did my training at Natividad. Yes, I did.

COMMITTEE MEMBER PACHECO: (Spoke in Spanish).

DR. TODD MAY: (Spoke in Spanish)

COMMITTEE MEMBER PACHECO: (Spoke in Spanish.)

No, that's really good, because that's an area of, you know, interest for us at CalPERS with respect to the Monterey Bay Area. And the population in that particular area is very important. And I'm also -- I'm also from that area. I group up in Watsonville.

DR. TODD MAY: Nice.

COMMITTEE MEMBER PACHECO: So thank you so much, sir, and thank you Mr. Chairman for letting me have a little bit more flexibility in asking my questions.

CHAIR RUBALCAVA: Thank you, Mr. Pacheco.

Mr. -- Trustee David Miller, please.

COMMITTEE MEMBER MILLER: Thank you. Really appreciate the presentation, appreciate your time with us today. There are two areas I wanted to touch on and you've kind of proactively wandered into both areas. So the first was the whole issue of supply, supply, the

pipeline, as you put it. And I'm really pleased and encouraged to hear the work that you're doing there, in terms of improving access to that pipeline and to bring that cultural competency and have our -- the health care workforce more reflect our population.

This is a subject that I've brought up in this forum a number of times with -- over the years, but it seems to me that also just the capacity. You know, a pipeline is fine, but if your refineries don't have the capacity for the throughput, it seems to me that, you know, for 40 plus years I've been involved around health care, that we don't have the capacity we need. We've artificially constrained that, particularly as you get to the higher skill, you know, on up into physicians that the potential number of fabulous family practice physicians, neurosurgeons, anywhere along that scale is very much constrained. You've got lots of talented people with the capability to do that, to -- but we really hinder them all away from public education, all the way up through opportunities for junior college, college, graduate school, medical school, nursing school. It's very constrained.

And it's more a comment than something that -- but I think the industry has got to grapple with that, because if we're just relying on -- you know, UC Davis,

they're doing great things, but they can't overnight, without a real strategic effort and being pushed, double our quadruple their capacity, their throughput, the size of their medical college. So that's something that I --

DR. TODD MAY: Can I make a comment on that?

COMMITTEE MEMBER MILLER: Sure.

DR. TODD MAY: I could not agree with you more, Mr. Miller. I mean, that's exactly right. And one other thing I do want to mention. My colleagues at UCSF are working now with UC Merced to set up a medical school at UC Merced. I think that's great and I think this is going into the direction of one more supply, but also being in the Central valley, more diversity, hopefully more really focus on Latino students pipeline there. I think there's a great opportunity. I'm a product of the Central Valley myself. I was born in Woodland and largely grew up in Fresno, so I'm very familiar with the area.

And I think that's the kind of thing we need to do. We need to change the landscape. And I'm going to tell you it comes down to dollars like most things, right, and who gets the dollars, and where the resources go, and all that. It's a big health policy issue, but we have to confront it.

COMMITTEE MEMBER MILLER: Yeah. And then the second thing I'd like to kind of touch on and get your

thoughts, again I'm really encouraged to see the recognition of kind of an integrative model of everything and the importance of behavioral health. Especially during the pandemic, we saw that across the board, the needs really highlighted some of the gaps, and -- but it also brought to bear the value of the telehealth for delivery and for access, but I think -- I'm curious, in terms of kind of, you know, you talked about the inverted pyramid in terms of providing health care. On the behavioral health side, I think we're seeing a lot of the same challenges with workforce, but it seems that it's, in many ways, the opposite. We've got a lot, in terms of scope of practice of that workforce, I guess when -- on the behavioral health side, it seems to be much more difficult to provide specialty care beyond care that's provided typically by, you know, master's level psychology, practitioners versus psychiatrists, versus specialized therapists.

On the physical side of things, if you go in and you've got your primary care physician and, oh, you need to a dermatologist and a cardiologist. Not a problem, we know how to do that and we're getting better at integration and -- but on the behavioral health side, I hear a lot from folks who have dual diagnosis, multiple diagnosis, who really have to choose or are assigned to

their -- who it's pretty much one size fits all. They basically only have access to primary care practitioners on behavior health side or have to choose do I address eating disorder or do I address my trauma disorders or my substance disorders? And I'm just wondering how that's been for you and how you're grappling with that?

DR. TODD MAY: Yeah, I think that's a very interesting observation, Mr. Miller. I mean, you're right, I mean it's a little bit of the opposite end of the spectrum in behavioral health compared to physical health. Few are really specialized practitioners. I think -- and then that's particularly acute in -- across geographies, right? And the more rural areas and -- the access is even more reduced. Oftentimes, it's for basic behavioral health service, let alone more specialized.

So I think -- I had mentioned that telehealth is particularly well-suited for behavioral health. And I'll tell you why. One, it's not -- it's not reliant on physical examination, and vital signs, and things that need to be done in person, so it can be done remotely. When folks often -- it reduces barriers and stigma. So rather than going to a behavioral health center in person, they can just do it online.

Think of someone who's so depressed they have trouble getting out of bed, let alone taking two buses to

go across town to get to an in-person appointment, they can do that online. And a really interesting finding from my colleagues at behavioral health is when they actually see the environment where people live, they get a whole new window to their life that they actually don't get an in-person visit.

So that's just a commentary on the power of telehealth in the behavioral health space in particular, and I think it also opens the door then to enhance access to the limited specialists in the limited geographies that you can expand that access through telehealth. So I think there are some -- there's some latitude here that isn't just contingent on supply, but it's a matter of maybe allocating the resources a little differently. So I'm a little more optimistic in that regard.

COMMITTEE MEMBER MILLER: Yeah, and I would think that as important as the cultural competency and language competencies are, it's even more of a premium for those in terms of the impact on behavioral health and telehealth.

DR. TODD MAY: Yeah, absolutely. And that's why I think it -- as Mr. Pacheco had mentioned, I mean, we really have to attend to cultural competencies while -- as well as language concordance, and if -- short of that, high quality interpreters.

COMMITTEE MEMBER MILLER: Thank you. Really

appreciate it and thanks again for being here and sharing this time with us.

DR. TODD MAY: Thank you very much. Thanks for having me.

CHAIR RUBALCAVA: Thank you, Mr. Miller.

That concludes our discussion from the Board. I do want to thank you for an excellent presentation. And I really appreciate the discussion we had on how we integrate behavioral health. And that's one thing that you guys do as a primary care how to integrate both of these. And particularly, I think developed networks it shows -- if it's selected in your premium price and I appreciate that, that you can provide quality health care at a very affordable price for our members, so we thank you for that. Thank you again

DR. TODD MAY: Thank you very much.

BRIAN TERNAN: Thank you.

CHAIR RUBALCAVA: So we have -- before we go on to the next item, we do have public comment on this item.

J.J. Jelincic.

J.J. JELINCIC: J.J. Jelincic, Director of Health for RPEA. I appreciate these spotlights. They give our members additional insights into the health plans. I've had staff pass out a -- part of my presentation.

Despite what the agenda item said, the 2024

increase for Salud y Más was 3.97 percent. That was even after the Board added $137 to the premium, because it was too low. That surcharge was over 26 percent of the total dollar premium, and over five times the dollar increase.

For 2025, Salud y Más did not get the message. The increase will be 14.73 percent and that includes $174 surcharge, over 30 percent of the negotiated rate, and 1.8 times the total dollar premium increase. Maybe next year they will get the message that this Board prefers and rewards high premiums. It actually taxes low-cost efficient plans. I want to point to the PPOs, since the so-called Risk Mitigation Plan is about protecting PERS Platinum. Gold negotiated a rate increase of $66. Platinum negotiated a rate increase of $356, and this is for '25. Since both have the same risk score, which is hard to believe, since Gold has both a smaller network and lower benefits, yet, a risk score of 1.1242 leads to a $19 surcharge for the lower cost Gold and a $234 premium for the higher cost Platinum.

No wonder CalPERS considers the calculation of risk scores to be a trade secret. Governments long ago learned that if you want more of something, you subsidize it. If you want less of something, you tax it. This Board clearly by its actions has indicated that it wants more high-cost, low-efficiency plans. I'm -- I would

request that my handout be included with my statement in the record. And I thank you for your time.

CHAIR RUBALCAVA: Thank you and it shall be in the record.

Okay. Now, we proceed to the next item, Item 3, Executive Report. Kim Malm and Don Moulds, please.

DEPUTY EXECUTIVE OFFICER MALM: Good morning. Kim Malm, CalPERS team member. I wanted to provide a few updates for you today. I'll start first with our Benefit Verification Project. As you recall, we sent out 8,700 letters in March to retirees to verify benefits. From this effort, 214 deaths were identified. Last I reported to you in September, there were 194 deaths identified. Deaths are now spread across 26 different states. In September, there were 24 different states. The deaths resulted $1.9 million of overpayments and we've now collected 1.6 million of that 1.9, or 82 percent. We were at 77 percent in September.

Again, in July, we began utilizing Socure as our death verification vendor. To date, Socure has report 354 confirmed deaths to us, resulting in $3.4 million of overpayments. And thus far, we've been able to collect 2.2. We are still working on these efforts.

The combined Benefit Verification Project and death verification with Socure has found almost 570 deaths

in the last few months with a little over $5.3 million of overpayments and 3.8 million being collected in the last few months. I'm happy to see these efforts are helping to reduce our death overpayments and improve our collection process, I'll be talking about this in much more detail at our Finance and Administration Committee today.

The next thing I was going to bring to you is an update to our CalPERS Benefit Education Events. We concluded the Sacramento one. We concluded the in-person ones in Sacramento in July with almost 2,000 attendees. Our next CBEE is virtual, December 11th and 12th, and registration just opened last week and we already have over 2,100 people registered.

Our next in-person CBEE is in Visalia, March 7th and 8th. And we have a tentative in-person one in the LA/Burbank area April 11th and 12th. We're also planning two virtual CBEEs next year in the summer and then also one in the fall/winter time frame.

As usual, I'll give an update on the retiree warrants. So far, over 7,600 retirees have checked their warrant through the phone or IVR process. And this rolled out back in October of last year. The myCalPERS online option, we've had almost 62,000 retirees check their warrant through that process and that rolled out back in January. I continue to be very happy with the utilization

by retirees of these two options that we've been able to provide them.

Last, since our last meeting, which was in mid-September, we had open enrollment. And open enrollment was mid-Oct -- or mid-September through mid-October. And during that time frame our Call Center received 115,000 calls during that one-month time frame. That's about almost 5,800 calls a day. All of the managers were on the calls along with our Call Center. And I just wanted to thank Carene George and her team for all of the hard work that they did during that time frame and helping our members during open enrollment.

And that concludes my remarks and I'm happy to turn it over to Don Moulds.

CHAIR RUBALCAVA: Thank you. We might have some questions before we go to --

DEPUTY EXECUTIVE OFFICER MALM: Sure.

CHAIR RUBALCAVA: Whoops. One moment.

Ms. Mullissa Willette.

COMMITTEE MEMBER WILLETTE: Thank you. Thank you so much for that report. I just wanted to take a moment to thank you for the work that you're doing and I'm continuing to be impressed with the work of the regional offices. I send members regularly to the regional offices and to the San Jose office in particular. This last

couple of months has been busy with the work of the members down in the Bay Area. And just again, their -- all the feedback is that all of the analysts are very impressive. They're really understanding. They're responsive to the needs of the members. And I really am just continually impressed with Mr. Rubio and your responsiveness and customer service to our beneficiaries. Thank you.

DEPUTY EXECUTIVE OFFICER MALM: Thank you. I'll be sure to share that with staff.

CHAIR RUBALCAVA: Thank you, Ms. Willette.

Mr. Palkki. Kevin Palkki.

VICE CHAIR PALKKI: Thank you. I'm not going to -- well ditto everything that Mullissa Willette said. But for the virtual CBEEs, are we tracking the zip codes in which those people are registering from? I'm just wondering if we're -- if we're able to utilize those to reach out to areas like Eureka or Barstow that are relatively --

DEPUTY EXECUTIVE OFFICER MALM: Mr. Rubio is shaking his head yes, so the answer to that would be yes.

VICE CHAIR PALKKI: Thank you.

DEPUTY EXECUTIVE OFFICER MALM: Uh-huh.

CHAIR RUBALCAVA: Thank you, Mr. Palkki.

Jose Luis Pacheco.

COMMITTEE MEMBER PACHECO: Yeah. Thank you, Chairman Rubalcava. Thank you very much. I wanted to ask you a question about the open enrollment. While you said you were about 115,000 you had and about 5,800 calls per day during open enrollment. During the open enrollment, were there any calls that were coordinated with Included Health with the new -- with the new PPO administrator and how that worked out.

DEPUTY EXECUTIVE OFFICER MALM: So Included Health had their own call center. And so members were -- there were members that absolutely called us --

COMMITTEE MEMBER PACHECO: Um-hmm.

DEPUTY EXECUTIVE OFFICER MALM: -- to get some information, but they also were able to call Included about the PPO. So Included only assisted the PPO active members.

COMMITTEE MEMBER PACHECO: Oh, I see, so -- and then they would be able to --

DEPUTY EXECUTIVE OFFICER MALM: So we took all the arrest.

COMMITTEE MEMBER PACHECO: You took all the rest. Perfect. And of that, how was -- I mean, how was the process? Was it very smooth? I mean, did people have a good experience when they got their information and so forth?

DEPUTY EXECUTIVE OFFICER MALM: With our call center?

COMMITTEE MEMBER PACHECO: Yes.

DEPUTY EXECUTIVE OFFICER MALM: I can't speak to the Included Call Center. Mr. Moulds would have to do that.

COMMITTEE MEMBER PACHECO: No. No, but --

DEPUTY EXECUTIVE OFFICER MALM: But, yeah, I mean, there was times with 5,800 calls a day that there was -- you know, they would be on hold for quite some time. And that's why we had all levels of management taking those calls along with all the Call Center agents is try to and help out, but it's -- it was a busy time. We're staff, as you know, for 3,000 calls a day and we had almost 5,800 per day.

COMMITTEE MEMBER PACHECO: I just wanted to compliment you and your staff and all the hard work you're doing. It's really wonderful to have you all there and help the membership.

DEPUTY EXECUTIVE OFFICER MALM: Great. Thank you.

BOARD MEMBER PACHECO: Thank you very much. That's all.

CHAIR RUBALCAVA: Thank you, Mr. Pacheco.

DEPUTY EXECUTIVE OFFICER MALM: Thank you.

CHAIR RUBALCAVA: Thank you. Mr. Moulds.

CHIEF HEALTH DIRECTOR MOULDS: Great. Good morning again. I'm going to use most of my time to touch on two issues that will impact our members. The first I want to share a progress report on the transition to Blue Shield and Included Health for our PERS Gold and Platinum members.

I'm pleased to report that on the medical care side, Blue Shield is on track to meet or exceed targets we set with them to limit the total number of disrupted members in both PERS Platinum and Gold. This includes the disruption targets for the rural 22 counties that we've talk about in the past.

Blue Shield is likely to miss, but be very close to the target for disruption on behavioral health providers. Come January 1st, they will be about a percentage short of their goal of 92 percent continuity. Closing the gap in the behavioral Health Net work has been challenging for a couple of reasons. Since most behavioral health providers are in smaller solo practices, expanding the network requires contracting -- contacting and coming to terms with providers one by one. As you all know, the shortage of behavioral health providers in California also makes this a particularly significant challenge.

I should remind you that Included Health will be supplementing our behavioral health offerings with their virtual behavioral health network. Those additional providers are not included in our disruption count, but will add considerable additional access for members who are struggling to find an in-person behavioral health provider or who prefer a virtual one.

During open enrollment, Included Health assisted over 1,400 Basic -- I'm sorry, 14,000 Basic PPO members with questions mostly to validate the in-network status of their providers to better understand their benefits -- or to better understand their benefits. Blue Shield received about 7,200 calls from our Medicare supplemental members seeking similar information.

It's important to remind you that even though we are largely on track to hit the disruption goal stipulated in the contract, that come January 1st, there will still be disruption for some of our members. We will have an -- we have a number of workstreams dedicated to minimizing disruptions, or helping members who do face disruption.

Since open enrollment, we've seen -- we've been helping members secure prior authorizations for pre-approval, so that they can continue receiving care for existing conditions as seamlessly as possible, when our new partners start in 2025.

And we've been working with Optum and Shield to ensure that the same is true for prescription drugs that members are currently taking.

We've also been working to ensure members enroll -- enrolled in clinical programs today, such as care management or specific disease management programs receive similar services beginning January 1st. We have started to communicate to members about the continuity of care protections in place and our -- and the limited out-of-network exception for 2025. Both afford members who qualify significant additional time to find an in-network clinician. We've also emailed members who are potentially facing disruption back on November 4th and are sending out second letter this week.

Included Health will be providing special assistance to any of our members facing a disruption in their care. And we continue to remind members of the important resources in webinars, briefings, and social media.

In December, Included Health will also start reaching out directly to Basic PPO members who saw a provider this past year that may not be in-network for 2025. Their goal is to make them aware of the continuity of care and limited out-of-network exception provisions where applicable or to help them locate high quality

in-network providers. The PPO transition has not been without its bumps. Over the past two months, there have been a handful of challenges including the disconnect on the information that's contained on the Medicare member ID cards, and understandable frustration on the part of members who are looking for definitive information about whether their provider will be in or out of the network come January.

Most of these have been due to the incredibly compressed timeline we are operating under, and in particular the fact that out of necessity were are still adding providers to the network. I will say that both Included and Shield have been exceptionally responsive and that we deeply appreciate their efforts. I also continue to be blown away by the dedication and hard work of the CalPERS team on this very challenging project.

The other thing that I want to alert you to is the signing of SB 729, which requires coverage for infertility and fertility services, including in vitro fertilization, as well as the medical cost associated with surrogacy. The new law is a big win for people who depend on these services in order to have a family and represents a major advance for health equity as it gives unpartnered members, LGBTQ members, and those lacking the financial means to pay out-of-pocket the ability to build a family.

At the same time, SB 729 will be very expensive. It requires that we cover up to three cycles of IVF. Factoring in the average number of cycles it takes to successfully conceive, which is about two and a half, the benefit costs about $75,000 per member who use this. All told, we anticipate that under current practices, the bill will add close to one percent to our premiums annually when applied to our State-regulated HMO plans and one and a half points, if we apply it to our PPO products as well. That will be the recommendation by the way, that we apply it across the Board.

Dr. Logan and I have had several conversations about the new law, both among one another and without outside partners. We are lockstep in our view that it's a golden opportunity to make meaningful progress on CalPERS health equity goals and that we are also going to need to be innovative in the rollout of the new benefit, so that we can control costs and ensure high quality. To that end, we been looking at employing a reference pricing type approach so that our members will receive the best care at the lowest prices. We have also been looking at innovative capitated benefit design models.

For CalPERS, the new mandate will go into effect in July of 2027. This gives us a good amount of time to develop a benefit that meets all of the aims here, having

high quality and cost effective benefit that is equity enhancing. We'll also be reporting out to you as we make progress. And ultimately, we'll be bringing you recommendations for the benefit design for your approval about a year from now.

Finally, I want to let you know that on November 1st, we delivered the Health Benefits Program annual report for 2023 plan year to the California Legislature and the Director of Finance. Throughout the report, you'll find insights about our different health plan offerings, including benefit design changes, medical trends, and financial information, providing an annual snapshot of our virtual -- of our vital work in support of our members' health and well-being. It's available on the CalPERS site through the "Forms and Publications" page. We hope that you find the report informative and a helpful resource.

That concludes my comments. Happy to answer any questions you might have.

CHAIR RUBALCAVA: Thank you, Mr. Moulds. We do have some questions. We'll start with Trustee Walker.

COMMITTEE MEMBER WALKER: Thank you, Mr. Chair. Hey, Don, as we're -- as they're coming up, right, they're going to continue to add -- or try to add more physicians. So, as the new ones come online, I'm assuming -- I'm

making the assumption that some of them might be what a member had used before, but couldn't because they -- how do they get notified or is there a notification process?

CHIEF HEALTH DIRECTOR MOULDS: So we have basically a regular transfer of that information from Blue Shield to Included Health, where a -- where a member has a provider who is not in network at the time they are working with Included Health. The message Included Health is providing is at this time, they're not part of the network. They explained that we continue to add. We are just -- candidly, we're getting close to the point where the additions are smaller and smaller, so -- that I used this example when I was talking about behavioral health, but where most of the practitioners are solo practitioners.

We've added the big -- the major medical groups, which bring a lot of bang for your buck, so there are sometimes thousands at a time. As you go down and add, it becomes much more of these sort of one-off solo practitioners. So the network is getting a little bit bigger, but not, you know, demonstrably bigger. So they have modified sort of the message as it gets more likely that there will be disruption there. And then in December, they're actually reaching out. That's when we just take the snapshot and say, okay, this is -- this is

what the network looks like. We're very close to there. And they reach out to those members who are disrupted and they start working with them. And then the two things they work through are the continuity and the out-of-network provisions, where applicable. A then, of course, helping them find somebody who's in-network who is a high quality Provider.

Did I answer your question?

COMMITTEE MEMBER WALKER: Yes. And I'm trying to formulate another one, so I'm going to just pass until I get to it. I thought I had it. Sorry.

CHIEF HEALTH DIRECTOR MOULDS: You have it on.

COMMITTEE MEMBER WALKER: Yes, you did answer. I have a follow-up, but it's not fully baked yet --

CHIEF HEALTH DIRECTOR MOULDS: Well, let it bake. I'm here.

COMMITTEE MEMBER WALKER: So as soon as it is, I'll let you know.

CHIEF HEALTH DIRECTOR MOULDS: Yep.

COMMITTEE MEMBER WALKER: Okay.

CHAIR RUBALCAVA: Thank you, Yvonne.

Lisa -- Trustee Lisa Middleton, please.

BOARD MEMBER MIDDLETON: All right. Thank you. This isn't a question. It's a comment. I want to thank Dr. Logan, Don, and everyone on the CalPERS staff for your

leadership on the IVF issues, particularly as it relates to LGBTQ community. As a proud member of that community, I know how many new lives will be coming into being, because of the legislation we're doing here. The families that we are helping to move forward, this is a moment I'm incredibly to be a member of this Board.

CHAIR RUBALCAVA: Thank you, Ms. Middleton.

Thank you.

Anything else?

CHIEF HEALTH DIRECTOR MOULDS: Are we -- are you still letting it bake?

CHAIR RUBALCAVA: Yvonne.

COMMITTEE MEMBER WALKER: (Nods head).

CHIEF HEALTH DIRECTOR MOULDS: Okay. Yes, I think we're good.

CHAIR RUBALCAVA: Okay. You can always come back, Yvonne.

Okay. So we'll now proceed to the action consent items. Do I have a motion to accept the September minutes.

COMMITTEE MEMBER MILLER: So moved.

VICE CHAIR PALKKI: Second.

CHAIR RUBALCAVA: So moved by Mr. Miller, second by Mr. Palkki. Thank you. Do we need a roll call?

Yes. Everybody say yes?

(Ayes).

CHAIR RUBALCAVA: Everybody should vote not yes.

I'm sorry. I misspoke there.

Okay. Do I have a motion to accept the timed agenda for next -- for November 19th's -- for this meeting, the agenda?

COMMITTEE MEMBER PACHECO: I move.

COMMITTEE MEMBER MILLER: I moved them all.

CHAIR RUBALCAVA: Move them all. Okay. I'm sorry, the motion was to move everything, by --

COMMITTEE MEMBER TAYLOR: It's action consent.

CHAIR RUBALCAVA: Acton and consent. Thank you.

I'm learning this, you guys. Thank you.

You got it okay. All right. I'm just looking.

Okay. We'll move into information consent items, number five. I had nothing from anybody, so we'll move on to Item 6. And we'll start with the -- Rob. I see Rob there and Dr. Logan, so...

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

(Slide presentation).

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF JARZOMBEK: This is Agenda Item 6a, approval of the Health Benefit Program proposals for the 2026 plan year.

This is an action item.

As quick background, a few years ago, we implemented a formalized process to review proposals outside of the rate development process. This separate process allows us to consider a variety of changes to our program for the upcoming plan year before the rate-setting process begins. This was done so that everyone knows what, any anything, is changing for the next plan year before any rates are developed. These potential changes include adding a new Basic or Medicare plan, incorporating a new health benefit program, making a benefit design change, or adjusting a current plan's service area.

[SLIDE CHANGE]

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF JARZOMBEK: Over the next few slides, I'll cover the timeline and walk through the service area expansions and benefit design proposal.

[SLIDE CHANGE]

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF JARZOMBEK: We solicited proposals from our internal teams in the health plans in August. Throughout this process, we instructed the plans to assess how their proposals support our strategic goal of exceptional health care. As a health team, we are continually developing ways to further enhance our program through the benefits

we offer. Our team has reviewed and analyze the proposals and developed recommendations for you. If approved, these changes will be incorporated into the rate development process and will take effect on January 1st, 2026, unless otherwise noted.

[SLIDE CHANGE]

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF JARZOMBEK: To align with our strategic goal, we looked for proposals that improve health care quality, increase equity, and maintain affordability. We also specifically encourage the plans to submit proposals that improve access to care for members, especially those living in areas that lack affordable HMO options.

Through the recent HMO solicitation, we made it clear to the plans that we expect them to continue to expand access of lower cost HMOs to new areas. The plans listened and we are please to share the following proposals for 2026 starting with Kaiser.

[SLIDE CHANGE]

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF JARZOMBEK: Kaiser Permanente is proposing to expand full coverage in Monterey County. This comes after they added 14 zip codes for their Basic plans starting next year in the northern part of the county covering the cities of Salinas and Monterey. Kaiser's proposal for

2026 is to expand their service area to all of Monterey County. This expansion includes Kaisers' Basic plan and both Medicare plans, which are Senior Advantage and Senior Advantage Summit.

Kaiser's entry into all of Monterey County would add an additional health plan option for Basic and Medicare members. It would also bring more competition into a county that has traditionally lacked competition.

The expansion is subject to a successful provider contracting efforts currently underway, as well as regulatory approvals from the Department of Managed Health Care, DMHC, and the Centers for Medicare and Medicaid Services, CMS, as applicable. We recommend approval of this expansion.

Next is UnitedHealthcare.

[SLIDE CHANGE]

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF JARZOMBEK: UHC is proposing to expand its SignatureValue Harmony Plan into El Dorado, Nevada, Placer, and San Joaquin counties. The continues their planned Northern California expansion, which includes expansions to Santa Clara and Santa Cruz counties in 2024 and Contra Costa, Napa, and Solano counties in 2025.

Harmony was previously a Southern California -- Southern California-only plan. As you may recall, during

the last solicitation, we pushed them to expand north. UHC agreed to a multi-year and multi-county expansion plan. And 2026 will be the third year of that five-year plan. UHC already received DMHC approval for this expansion.

We recommend approval of this expansion.

[SLIDE CHANGE]

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF JARZOMBEK: Now, switching to a benefit design proposal. California Assembly Bill 2843 was recently signed and chaptered into law. It will require health plans regulated by the DMHC to eliminate any cost sharing to the member for the first nine months after the member initiates treatment following a rape or sexual assault. The law is set to take effect for HMO plans on July 1st of 2025. We propose to apply this newly chaptered law to our PPO health plans and to adopt this benefit for both HMO and PPO plans as early as January 1st of 2025, earlier than required, given its potential impact to members.

[SLIDE CHANGE]

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF JARZOMBEK: Finally, we are considering making two potential changes that only impact the Basic PPO plans. Given there is no impact to the HMO plans, we continue to refine these items and plan to return to you in March with

more detail.

The first potential change is to make revisions to the current value-based insurance design, or VBID, program within the PERS Gold Basic plan. What we're exploring here are ways to further align the program with our strategic goals to improve clinical quality for our members. The second potential change is to explore a lower cost Basic PPO option for out-of-state members. We are evaluating the options available for 2026 and if we can develop a viable one, we will bring it back to you in March.

Again, neither of these potential changes will impact the HMO health plan rate submissions for 2026, as they are exclusive to the Basic PPO plans.

[SLIDE CHANGE]

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF JARZOMBEK: Here is a quick recap of the proposals we recommend for approval. First is Kaiser's expansion of its Basic and Medicare plans across all of Monterey County. Second is UHC's SignatureValue Harmony expansion into El Dorado, Nevada, Placer, and San Joaquin counties. And third is no member cost sharing for treatment for sexual assault and rape across our HMOs and PPOs.

[SLIDE CHANGE]

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION

CHIEF JARZOMBEK: Upon the Committee's approval, will incorporate the approved changes into the rate development process and lay out the necessary implementation activities. We will communicate the plan expansions and benefit design changes to members in advance of and during open enrollment. We will present the 2026 health premiums to the Board for final approval next July, with discussions about the initial and preliminary rates in the months leading up to that.

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

CHAIR RUBALCAVA: Thank you.

CHIEF HEALTH DIRECTOR MOULDS: Mr. Chair, if I can add one thing?

CHAIR RUBALCAVA: Please.

CHIEF HEALTH DIRECTOR MOULDS: Thank you. I just wanted to -- I wanted to highlight that the expansion of Kaiser into Monterey County is, at this point, highly aspirational. I don't want folks to get their hopes up too much. We're asking for authorization, because we are looking -- we are working hard to try to help with that process, but the odds of it happening at this point are not high. There are a handful of health systems and hospitals in that county, as we've talked about in the past that make it extraordinarily challenging. It doesn't

mean that it's not a goal for us, but I just wanted to -- I just wanted reiterate that.

CHAIR RUBALCAVA: No. We're appreciate that soberness. We understand the complexities. Thank you, Dr. Logan and Rob for your presentation.

I don't -- any -- yes, we have questions from the Committee. Ms. Willette. Mullissa.

COMMITTEE MEMBER WILLETTE: Thank you. Thank you so much for the presentation. I appreciate the work staff -- and thoughtfulness going into it. I'm in favor of the recommendation, but I did want to ask, understanding the expansion into Monterey is aspirational, if we could add more to that aspiration list, that San Benito County is another county that I think is sandwiched right there. And the Majority of the population is right between Santa Clara County and Monterey County, and maybe that would be something we could look into for future years. I know that the residents and their members in San Benito County also need access to the health care. And it's -- the population is just so densely in one area of the county, that maybe that that would be something we could talk with our providers, specifically maybe if Kaiser is expanding into that area as well.

CHIEF HEALTH DIRECTOR MOULDS: Absolutely.

CHAIR RUBALCAVA: Thank you.

Ms. Walker.

COMMITTEE MEMBER WALKER: Thank you. I appreciate the -- I approve -- I support the proposals. I also appreciate, Don, you managing our expectations. That's really nice and this isn't about the presentation. This is like in the future or looking. So I know that at one point, Kaiser had expanded down into southern Oregon, right, which abuts our people in Del Norte County. And so is there a way for -- to look at -- to see can our members use that service, even though it's a different state? And have we looked at like even around the surrounding states, like we -- you know, we abut, what, Nevada, Arizona. And I'm sure they have some of the same health plans, you know.

And I'm sure you guys have looked at it, but, you know, has there been -- I think things evolved. And so I don't when the last time you looked at it, but to see that -- could that be a possibility, because it would help not only retired members who live, you know, out in the outer places, but also for actives that live up in -- because I know a lot of them live in Oregon, right, live in Oregon or right across the border into Nevada, and the same with Arizona.

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF JARZOMBEK: Yeah. So just to answer that piece, so

if the -- if the member is living or has a work zip code that is within the Kaiser service areas, then they should be -- they are able to utilize the Kaiser in that area. So if it is in Oregon, they are able to utilize that -- those Kaiser facilities. So that happens already, is available them already.

COMMITTEE MEMBER WALKER: Okay.

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF JARZOMBEK: And then it's also -- they have other service areas throughout the U.S. just I know in a few different states.

COMMITTEE MEMBER WALKER: Right.

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF JARZOMBEK: And so it's available to those members, typically retired of course, who are living in those areas. But they're -- those members are allowed to seek services at that facility, whether it's in-state or out of state, if they -- if they are enrolled in that program.

COMMITTEE MEMBER WALKER: Okay. And what about the health plans then?

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF JARZOMBEK: So it would be --

COMMITTEE MEMBER WALKER: Is it the same thing?

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF JARZOMBEK: It would be a similar situation. Kaiser

has the most that --

COMMITTEE MEMBER WALKER: Right.

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION CHIEF JARZOMBEK: -- has -- is out there. But for the PPOs, then that would be the same thing as well.

COMMITTEE MEMBER WALKER: Okay.

CHIEF HEALTH DIRECTOR MOULDS: Yeah, we have a -- there are a few examples of member -- of pockets of membership close to a border, where the larger health systems are on the other side of the border. The one I'm thinking of is Truckee --

COMMITTEE MEMBER WALKER: Right.

CHIEF HEALTH DIRECTOR MOULDS: -- and Reno, and it's the same thing. So we have a number of members who receive most of their health care on the Nevada side of the border.

COMMITTEE MEMBER WALKER: Okay. All right. And then just one last thing. On the last call I did with retirees, we had an interesting caller that came up who lives part time Morocco and then part time here, and they're -- and getting health care having to come back to the States to get health care. And is there -- and then I got emails afterwards of other people living in other places, you know, part time which was --

CHIEF HEALTH DIRECTOR MOULDS: We have people all

over the world, and --

COMMITTEE MEMBER WALKER: Right.

CHIEF HEALTH DIRECTOR MOULDS: -- they get health care all over the worlds. So the short answer is that -- is that most of that care is provided. So we do have -- we do have -- for the PPO members in particular, we have global coverage.

COMMITTEE MEMBER WALKER: Okay.

CHIEF HEALTH DIRECTOR MOULDS: And -- but it is on a reimbursement basis. If the event takes place outside of the United States, the network is -- I think it's GeoBlue is the Blues network that gets tapped for that at both Anthem and -- I'm looking at Dr. Logan to make sure I've got this right, but both Anthem and Blue Shield use a very similar network. It is sometimes cumbersome, but it does provide the coverage.

COMMITTEE MEMBER WALKER: Okay. And it's reimbursement, okay.

CHIEF HEALTH DIRECTOR MOULDS: It is. It is.

COMMITTEE MEMBER WALKER: Okay. Thank you.

CHAIR RUBALCAVA: Thank you.

Now, we proceed to Mr. Jose Luis Pacheco.

COMMITTEE MEMBER PACHECO: Yes. Thank you, Mr. Moulds and thank your team for your presentation.

I just wanted to say I also support the

endeavor -- the initiatives with respect to expanding to Kaiser in the Monterey Bay area. As I've -- as I i've mentioned earlier -- many times, I'm from that area and it is very well -- it is very important for the members down there to have that access, as well as the expansion to the four continues up in Northern California, and especially the bill for covering the rape and sexual assault. Very, very important. And I'm glad that we have -- we're finally going to do something about that. And the Legislature finally pushed it forward. So I just wanted to compliment you for your strong efforts and all your hard work in doing this. Thank you

CHAIR RUBALCAVA: Thank you, Mr. Pacheco.

Ms. Willette.

COMMITTEE MEMBER WILLETTE: Thank you. So I'll move approval of the staff recommendations of the two service area expansion and one benefit design change.

COMMITTEE MEMBER TAYLOR: Second.

CHAIR RUBALCAVA: Thank you. And we have second Ms. Taylor. President Taylor.

COMMITTEE MEMBER TAYLOR: That's okay.

CHAIR RUBALCAVA: Thank you.

So now, all those in favor, say aye, please?

We have a motion and a second.

So all those in favor, please say aye?

(Ayes.)

CHAIR RUBALCAVA: So any opposed?

Any abstentions?

So the ayes have it. So the motion passes.

Thank you very much staff. And again, I also want to join with my -- the colleagues, all the comments they made that we are very -- we're very pleased that staff moved from July to a January effective date, the provisions of a AB 2043, the no cost for treatment -- no employee cost of rape and sexual assault, and also the efforts in Monterey County. And I am pleased UnitedHealthcare Harmony will be expand -- continuing their expansion into Northern California. Thank you, everybody.

So now, we'll move on to information items. Do we have any? Item number 7.

COMMITTEE MEMBER TAYLOR: Nothing there.

CHAIR RUBALCAVA: Nothing there.

Okay. One moment. Let me my agenda up to date. Okay. We have no summary of Committee direction, Don?

CHIEF HEALTH DIRECTOR MOULDS: I don't have anything.

CHAIR RUBALCAVA: Okay. Good.

So now, we'll go to public comment. Do we have any public comment?

BOARD CLERK ANDERSON: No.

CHAIR RUBALCAVA: No public comment. So we'll now adjourn into closed session in six minutes. We'll start closed session at 10 o'clock.

Thank you.

(Off record: 9:54 a.m.)

(Thereupon the meeting recessed into closed session.)

(Thereupon the meeting reconvened open session.)

(On record: 10:53 a.m.)

CHAIR RUBALCAVA: Okay. We're back in open session and this adjourns the Pension and Health Benefits meeting. And the Risk and Audit Committee will begin in 15 minutes. We'll take a 15-minute break.

Thank you.

(Thereupon California Public Employees' Retirement System, Pension and Health Benefits Committee open session meeting adjourned at 10:53 a.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 24th day of November, 2024.

JAMES F. PETERS, CSR
Certified Shorthand Reporter
License No. 10063

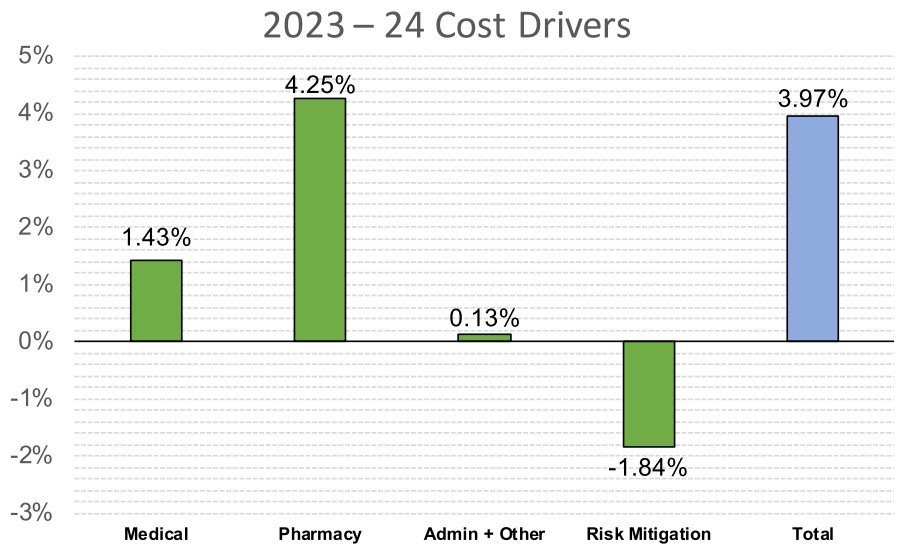
Approval of 2024 HMO and PPO Premiums

Health Net Salud y Mas (Basic)

2023 Premium	2024 Premium Before Risk Mitigation	Adjusted Risk Score for 2024	Risk Mitigation Impact	2024 Premium	Percent Change from 2023
$631.89	$519.09	0.7805	$137.87	$656.96	3.97%

$112.80 Negotiated Decrease

Board Policy Surcharge



2023 Total Covered Lives: 11,920

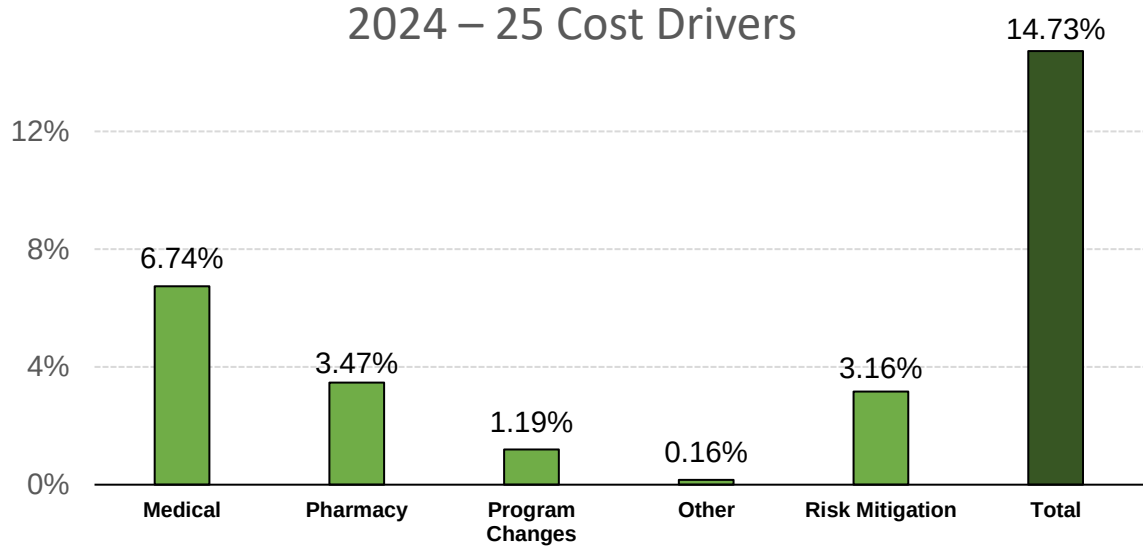
Approval of 2025 HMO and PPO Premiums

Health Net Salud y Mas (Basic)

2024 Premium	2025 Premium Before Risk Mitigation	2025 Adjusted Risk Score	Risk Mitigation Impact	2025 Premium with Full Transition to One Risk Pool	Percent Change from 2024
$656.96	$579.12	0.7634	$174.60	$753.72	14.73%

$77.84 Negotiated Decrease

Board Policy Surcharge



2024 Total Covered Lives: 12,524

Approval of 2025 HMO and PPO Premiums

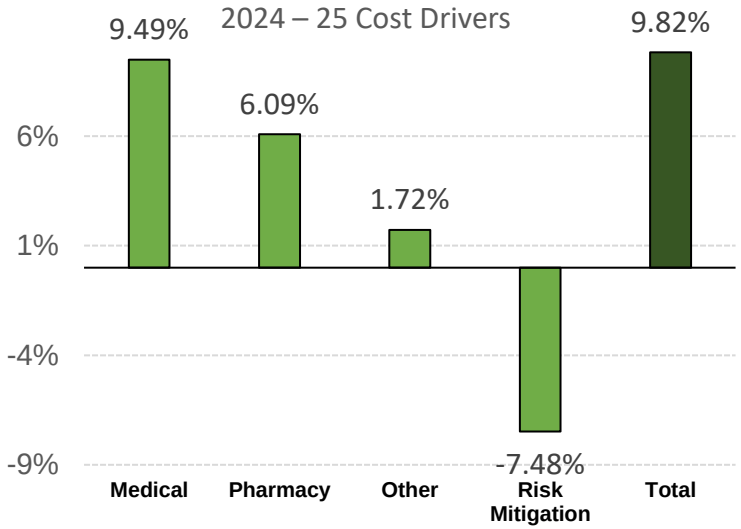
PERS Gold & Platinum (Basic)

Plan	2024 Premium	2025 Premium Before Risk Mitigation	2025 Adjusted Risk Score	Risk Mitigation Impact	2025 Premium with Full Transition to One Risk Pool	Percent Change from 2024
PERS Gold	$859.31	$925.92	1.1242	$17.79	$943.70	9.82%
PERS Platinum	$1,215.87	$1,569.70	1.1242	($234.40)	$1,335.30	9.82%
Basic PPO Weighted Average Change						9.82%

Same Risk Score

Negotiated Increase
Gold $66.10
Platinum $353.83

Board Policy
Surcharge for Gold
Subsidy for Platinum



PERS Gold 2024 Total Covered Lives: 134,966

PERS Platinum 2024 Total Covered Lives: 111,685