VIDEOCONFERENCE MEETING

STATE OF CALIFORNIA

PUBLIC EMPLOYEES' RETIREMENT SYSTEM

BOARD OF ADMINISTRATION

PENSION & HEALTH BENEFITS COMMITTEE

OPEN SESSION

ZOOM PLATFORM

TUESDAY, MARCH 16, 2021

9:00 A.M.

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

APPEARANCES

COMMITTEE MEMBERS:

Rob Feckner, Chairperson

Ramon Rubalcava, Vice Chairperson

Margaret Brown

Henry Jones

David Miller

Eraina Ortega

Theresa Taylor

Shawnda Westly

Betty Yee, represented by Karen Greene-Ross

BOARD MEMBERS:

Fiona Ma, represented by Frank Ruffino

Lisa Middleton

Stacie Olivares

Jason Perez

STAFF:

Marcie Frost, Chief Executive Officer

Matt Jacobs, General Counsel

Donald Moulds, PhD, Chief Health Director

Anthony Suine, Deputy Executive Officer

Kelly Fox, Chief, Stakeholder Relations

APPEARANCES CONTINUED

STAFF:

Pam Hopper, Committee Secretary

Julia Logan, MD, Chief Medical Officer

Karen Páles, Acting Chief, Health Policy Research Division

Kimberly Pulido, Chief, Retirement Benefit Services Division

ALSO PRESENT:

Tim Behrens, California State Retirees

Lisa Bocast

Leemore Dafny, PhD, Harvard Business School, Kennedy School of Government, Bates White

Laura Slavec

Larry Woodson, California State Retirees

INDEX

PROCEEDINGS

CHAIRPERSON FECKNER: So let's call the meeting to order. We'd like to call the Pension and Health Benefits Committee meeting to order.

First order of business will be to cal the roll.

Ms. Hopper, please.

COMMITTEE SECRETARY HOPPER: Rob Feckner?

CHAIRPERSON FECKNER: Good morning.

COMMITTEE SECRETARY HOPPER: Margaret Brown?

COMMITTEE MEMBER BROWN: Good morning.

COMMITTEE SECRETARY HOPPER: Henry Jones?

COMMITTEE MEMBER JONES: Here.

COMMITTEE SECRETARY HOPPER: David Miller?

COMMITTEE MEMBER MILLER: Here.

COMMITTEE SECRETARY HOPPER: Eraina Ortega?

COMMITTEE MEMBER ORTEGA: Here.

COMMITTEE SECRETARY HOPPER: Ramon Rubalcava?

VICE CHAIRPERSON RUBALCAVA: Here.

COMMITTEE SECRETARY HOPPER: Theresa Taylor?

COMMITTEE MEMBER TAYLOR: Here.

COMMITTEE SECRETARY HOPPER: Shawnda Westly?

CHAIRPERSON FECKNER: Excused.

COMMITTEE SECRETARY HOPPER: Karen Greene-Ross for Betty Yee?

ACTING COMMITTEE MEMBER GREENE-ROSS: Here.

COMMITTEE SECRETARY HOPPER: Mr. Chair, I believe all is in attendance with Shawnda Westly being excused.

CHAIRPERSON FECKNER: Thank you. And Shawnda will be on in a little while. She had video conference first. So when she comes on, she's going to put it in the chat box that she's back.

Item 2 will be election of the Pension and Health Benefits Committee Chair and Vice Chair. For the election of the Chair, I'm going to turn the gavel over to Mr. Rubalcava.

Mr. Rubalcava, please.

VICE CHAIRPERSON RUBALCAVA: Okay. I've accepted your gavel.

(Laughter.)

VICE CHAIRPERSON RUBALCAVA: So the order of business is the election of the Pension and Health Benefits Committee Chair.

Are there any nominations?

Ms. Taylor.

COMMITTEE MEMBER TAYLOR: Hi. I would like to nominate Mr. Feckner for Chair of the Pension and Health Benefits Committee.

VICE CHAIRPERSON RUBALCAVA: Is there a second?

COMMITTEE MEMBER MILLER: (Hand raised.)

VICE CHAIRPERSON RUBALCAVA: David Miller

seconds.

Okay. Any other nominations?

Any other nominations?

Any other nominations?

So I guess nominations are closed and Mr. Feckner you can reassume your position as Chair of the Pension and Health Committee. Congratulations, Mr. Feckner.

CHAIRPERSON FECKNER: So you have to have a vote, Mr. Rubalcava.

VICE CHAIRPERSON RUBALCAVA: Sorry. Sorry. So we shall have a vote then.

Ms. Hopper, I guess you're calling the vote, taking the vote.

COMMITTEE SECRETARY HOPPER: Yes.

Margaret Brown?

COMMITTEE MEMBER BROWN: Aye.

COMMITTEE SECRETARY HOPPER: Henry Jones?

COMMITTEE MEMBER JONES: Aye.

COMMITTEE SECRETARY HOPPER: David Miller?

COMMITTEE MEMBER MILLER: Aye.

COMMITTEE SECRETARY HOPPER: Eraina Ortega?

COMMITTEE MEMBER ORTEGA: Aye.

COMMITTEE SECRETARY HOPPER: Ramon Rubalcava?

VICE CHAIRPERSON RUBALCAVA: Aye.

COMMITTEE SECRETARY HOPPER: Theresa Taylor?

COMMITTEE MEMBER TAYLOR: Aye.

COMMITTEE SECRETARY HOPPER: Shawnda Westly excused.

Karen Greene-Ross for Betty Yee?

ACTING COMMITTEE MEMBER GREENE-ROSS: Aye.

COMMITTEE SECRETARY HOPPER: Mr. Chair, I have all ayes, motion made by Theresa Tailor, seconded by David Miller for the election of the Chair of the Pension and Health Benefits Committee, Rob Feckner.

VICE CHAIRPERSON RUBALCAVA: Congratulations, Mr. Feckner. Now, I can congratulate you.

CHAIRPERSON FECKNER: Thank you, sir. Thank you, Ms. Hopper. And thank you fellow committee members. I truly appreciate the vote of support.

Now, the next up is the election for the Vice Chair of the Pension and Health Committee. For that, I will now open up the floor for the nominations. Are there any nominations?

Mr. Miller.

COMMITTEE MEMBER MILLER: Yes. I nominate Director Ramon Rubalcava.

CHAIRPERSON FECKNER: Very good.

Are there any further nominations for Office of Vice Chair?

COMMITTEE MEMBER TAYLOR: I'll second.

CHAIRPERSON FECKNER: It's been seconded. We don't need seconds, but that's okay. It shows support.

Any further nominations for the Office of Vice Chair?

Third and final time, any nominations for the Office of Vice Chair of Pension and Health?

Seeing none.

I will entertain a motion for Mr. Rubalcava to be elected Vice Chair.

COMMITTEE MEMBER JONES: Move approval.

CHAIRPERSON FECKNER: Moved by Mr. Jones.

COMMITTEE MEMBER MILLER: Second.

CHAIRPERSON FECKNER: Seconded by Mr. Miller.

Ms. Hopper, please call the roll.

COMMITTEE SECRETARY HOPPER: Margaret Brown?

COMMITTEE MEMBER BROWN: Aye.

COMMITTEE SECRETARY HOPPER: Henry Jones?

COMMITTEE MEMBER JONES: Aye.

COMMITTEE SECRETARY HOPPER: David Miller?

COMMITTEE MEMBER MILLER: Aye.

COMMITTEE SECRETARY HOPPER: Eraina Ortega?

COMMITTEE MEMBER ORTEGA: Aye.

COMMITTEE SECRETARY HOPPER: Ramon Rubalcava?

VICE CHAIRPERSON RUBALCAVA: Aye.

COMMITTEE SECRETARY HOPPER: Theresa Taylor?

COMMITTEE MEMBER TAYLOR: Aye.

COMMITTEE SECRETARY HOPPER: Shawnda Westly excused.

Karen Greene-Ross for Betty Yee?

ACTING COMMITTEE MEMBER GREENE-ROSS: Aye.

COMMITTEE SECRETARY HOPPER: Mr. Chair, I have all ayes, motion made, I believe, by Henry, seconded by David Miller, correct?

COMMITTEE MEMBER MILLER: (Nods head.)

CHAIRPERSON FECKNER: Yes.

COMMITTEE SECRETARY HOPPER: And it is for the election of the Vice Chair of the Pension and Health Benefits Committee Ramon Rubalcava.

VICE CHAIRPERSON RUBALCAVA: Thank you, everybody.

CHAIRPERSON FECKNER: Thank you. Congratulations, Ramon.

I'm going to try and reconnect on my phone. For some reason, it died. I'll be right back here.

Hold still.

It wasn't the phone. It jus wouldn't --

COMMITTEE MEMBER TAYLOR: We can hear you, Rob.

VICE CHAIRPERSON RUBALCAVA: Can you hear us, Rob? Are you there?

We see you.

CHAIRPERSON FECKNER: I can hear you. But if I don't get the phone, then you're not going to hear me well enough, so I'm going to try and get the phone hooked on.

COMMITTEE MEMBER TAYLOR: We can hear you, Rob, by the way, without the phone?

CHAIRPERSON FECKNER: Okay. Let's see what happens. Can you hear me now?

VICE CHAIRPERSON RUBALCAVA: Yes, we can.

COMMITTEE MEMBER TAYLOR: Now, you have an echo with the phone and --

CHAIRPERSON FECKNER: All right. Well, we'll continue on -- I turned the phone back off.

COMMITTEE MEMBER TAYLOR: Yeah, because we can hear you.

CHAIRPERSON FECKNER: All right. Well, we'll see how it goes. Next up is the item 3, approval of the March 16th timed agenda. What's the pleasure of the Committee? Do I have a motion?

COMMITTEE MEMBER BROWN: Move approval. Ms. Brown.

COMMITTEE MEMBER TAYLOR: Second.

CHAIRPERSON FECKNER: It's been moved by Ms. Brown, seconded by Ms. Taylor.

Any discussion on the motion?

Seeing none.

Ms. Hopper.

COMMITTEE SECRETARY HOPPER: Margaret Brown?

COMMITTEE MEMBER BROWN: Aye.

COMMITTEE SECRETARY HOPPER: Henry Jones?

COMMITTEE MEMBER JONES: Aye.

COMMITTEE SECRETARY HOPPER: David Miller?

COMMITTEE MEMBER MILLER: Aye.

COMMITTEE SECRETARY HOPPER: Eraina Ortega?

COMMITTEE MEMBER ORTEGA: Aye.

COMMITTEE SECRETARY HOPPER: Ramon Rubalcava?

VICE CHAIRPERSON RUBALCAVA: Aye.

COMMITTEE SECRETARY HOPPER: Theresa Taylor?

COMMITTEE MEMBER TAYLOR: Aye.

COMMITTEE SECRETARY HOPPER: Shawnda Westly, excused.

Karen Greene-Ross for Betty Yee?

ACTING COMMITTEE MEMBER GREENE-ROSS: Aye.

COMMITTEE SECRETARY HOPPER: Mr. Chair, I have a motion made by Margaret Brown, seconded by Theresa Taylor for Item 3.

CHAIRPERSON FECKNER: Thank you very much.

That brings us to Item 4, executive report. First up, I believe, is Mr. Suine.

DEPUTY EXECUTIVE OFFICER SUINE: Thank you. Good morning, Mr. Chair and members of the Committee. I'm

Anthony Suine, CalPERS team member.

And I'd like to first congratulate, Mr. Chair and Mr. Vice Chair on your reelections, and I look forward to continue working with you going forward.

Grateful to have survived the last year when I presented in front of you for the first time in my new role as Deputy Executive Officer. And it's a little bit eerie to reflect on what I thought was ahead of us, and how it all played out, and how far we've come. A year ago, we were just beginning to imagine transitioning into a virtual environment, and now it feels somewhat normalized.

The last time I had an opportunity to present before you was in November, so I have a bit more to share today. To start, I'm pleased to report we continue to operate with more than 95 percent of our team working remotely and our customer service performance, satisfaction, and benefit payments are being sustained at high levels, meeting and exceeding our goal category.

And while our in-person services remain shutdown due to the pandemic, the regional offices have still delivered over 45,000 virtual member counseling appointments in 2020, the first year we offered services in this manner.

As I've shared previously, we have been

concentrating on our Customer Contact Center, where the wait times have sometimes been higher than either we or our members like, especially on the first day of the week. We've been working hard to mitigate these concerns by shifting workload to free more agents and redirecting more team members to the phones on those high volume days.

Our strategies are proving successful with wait times having been reduced by over 45 percent on the first day of the week, since we started our plan about six months ago.

The teams have worked really hard to put these mitigations in place and we'll continue to monitor workloads and trends on a daily basis to identify and incorporate new strategies.

We wrapped up 2020 with an increase in total retirements by one percent over the last year. Schools and public agencies decreased approximately seven percent, while State retirements increased approximately 15 percent. I mentioned before we've seen a huge adoption of our member self-service for retirement applications with nearly 70 percent of all retirement applications being submitted online.

We've now turned our focus to the service credit purchase process. If any of you have purchased service credit with CalPERS before, you know it was heavily paper

oriented with several back-and-forths between the member, CalPERS, and sometimes the employer. We have now incorporated many of those functions in the self-service portal. This change enables members to calculate the cost of a service credit purchase and electric from their member self-service account, as well as allowing employers to certify time through their myCalPERS log-ins.

The first phase of this was implemented in January of 2021. And to date, we have received more than 200 electronic requests to purchase service credit online, representing about 20 percent of the total requests received since we implemented.

As we do with new online offerings, we work with our partners in IT to conduct usability testing. We ask members to use the tool and let us know what they think about the new design. Our initial feedback has been very positive, every thing from, "I like it", "easy to navigate", to, "It led me along in the process and didn't leave me hanging at any point", and, "Finally, we can do this online".

As part of our ongoing strategic goals, we are looking to enhance and expand more services in the online portal going forward.

So even in our virtual environment, member education remains critical. In 2020, we've talked about

the two virtual Benefit Education Events that had over 15,000 class attendees in various offerings. Now, we're gearing up for our next virtual CalPERS Benefit Education Event to be held next week, March 24th through 25th. This will be an expanded offering. It will include 20 live class offerings over two days and 20 virtual exhibitors in live virtual rooms. It will also have 90 days of on-demand access to these classes for those members who registered for the event. These events keep getting better and better and I'm really inspired by how they have evolved over the time.

I wanted to provide a positive update on an outstanding issue that you may have been aware of in the past that we were recently able to resolve. As some of you may recall, a law was passed in 2007 allowing those who serve in the California National Guard to become CalPERS members. However, at the time, there was no method in place to report that service to CalPERS. The National Guard is a federal agency whose payroll methods differ from State agencies. And the California Department of Military is responsible for reporting the National Guard's payroll. But they are federal employees, and the Military Department did not have access to payroll information. This resulted in having no way to report critical attributes for CalPERS pensions to us.

While it took some time, I'm happy to report that through collaboration between multiple parties, including the State Controller's Office, the Military Department, and our internal CalPERS teams, we began accepting contribution reporting data in our myCalPERS system, enabling California National Guard members who have chosen to be enrolled in CalPERS membership to now have an automated process for payroll and service credit reporting.

Additionally, members can now also purchase past service credit as well. To date, we have approximately 25 National Guard members accruing CalPERS service with nearly 40 more pending information from the Military Department. It's nice to finally have these automated capabilities between our various departments.

Lastly, I wanted to share a special member story with you. It's been such a strange year and one that's given us plenty of opportunity to meet members' needs in new and creative ways. Our Walnut Creek regional office had become aware of a member who had lost his housing, and after hospitalization resulting from severe health issues, had been discharged to live-in care facility, unable to care for himself.

With live-in care facility restrictions in place due to the pandemic, the member did not have access to

visitors and he also did not have a mobile phone, and had limited means of communication. In January, a medical social worker with Kaiser contacted us for assistance in helping the member access his retirement benefits due to his disabled state.

Since then, several members of the CalPERS team have coordinated with the care facility and Kaiser to help the member, including the arrangement of witnessing the signature of his retirement application virtually. I'm happy to say through the earnest efforts of many dedicated and caring people, this gentleman is now receiving the benefits he has earned as a public servant.

This story is an example of how extremely proud I am of our team for managing the current environment and delivering on our mission of serving our members and employers. Our team has dealt with multiple challenges, but they continue to be resilient and our leadership has continued to be flexible with our team members.

To date, this flexibility theme has worked, enabling us to fulfill our mission and provide exceptional customer service while also allowing our team members the balance they need to manage their home lives. We hope to carry that momentum into the future with a combination of telework and working in the office, letting the team have a say in what their post-pandemic work arrangement will

look like.

I wish to thank the Board for your continued to support -- your continued support as we've navigated this bizarre year. And this concludes my update and I'm happy to take any questions.

CHAIRPERSON FECKNER: Thank you, Mr. Suine. Appreciate the update, especially the part about the National Guard, and more importantly the dedication that you guys put in to getting that member retired. So thank you to you and your staff for always being flexible in making sure that the members come first.

Seeing no questions, then we'll move to Mr. Moulds.

CHIEF HEALTH DIRECTOR MOULDS: Great. Thank you. Good morning, Mr. Chair and members of the Committee. Don Moulds, CalPERS team. I also want to congratulate Mr. Feckner and Mr. Rubalcava on your reelection to Chair and Vice Chair of the Committee. Our team looks forward to working with both of you again this year.

I'll start my remarks by providing an update on timing for the long-term care rate increase you adopted last November. We communicated with you then that the increase would take effect sometime after July 1st, 2021 for the first-year increase, and late in 2022 for the second-year increase.

We now know that the first-year increase is set to commence in November of 2021. The timeline for the second-year rate increase has not changed. This means that the offer letters to policyholders will be mailed this August. These are the letters that policyholders receive with specific policy change offers that, if accepted, would allow them to avoid the rate increase entirely. The offer letters will also remind policyholders of their right to contact our third-party administrator, Long Term Care Group, to arrange customized changes and benefit.

The delay of the first-year increase -- excuse me. The delay in the first-year increase from summer to fall was necessary because of significant upgrades we've instituted in the offers we're providing to our policyholders. In the past, policyholders received the same offer regardless of the specifics of their policy. These options will be provided -- the options we'll be providing in this rate increase will be tailored to individual policies and afford options for many -- two options for many policyholders. The tailored offers will help policyholders get more from their amended policies.

The addition of the policy options you approved in November and the decision tree we've integrated into the benefit offers require extensive coding changes, which

is a primary reason for the added time. The modest delay is not significant enough to require changes to the size of the required rate increase.

I also want to mention a trend that's been reported recently in the news and in the earning reports of some publicly traded long-term care insurance carries, and how it could potentially affect our needed rate increases.

As I've mentioned in the past, COVID has disproportionately killed individuals who are of the age where they require long-term care, and more specifically, it has killed residents of long-term care facilities at a very high rate. COVID has also made people more reluctant to use long-term care services, both to have a long-term care provider coming into their home regularly or to move into a long-term care facility.

Few publicly traded long-term care carriers have recently reported that these trends have reduced their short- and long-term liabilities. We're currently monitoring for this trend. To date, CalPERS has not seen material changes in either deaths of their policyholders or in deferred claims, though claims lag may be blinding us to some of these changes, particularly to premature death in our enrollees.

It's also worth noting that any slowing of the

use of long-term care services is likely to be short lived. As long as long-term care workers and aged people are vaccinated, the risk associated with receiving services has gone down. And as anxieties associated with the use of long-term care services goes down, industry experts expect a return to regular use patterns.

Any reduction in liabilities we do see will be passed along to our policyholders, most likely in the form of reductions in the second-year rate increase. We'll let you know of any developments related to this issue.

The next item I want to share is that we are underway with our Risk Mitigation Strategy as part of the two-year implementation of portfolio rating for our basic health plans. This includes the development of risk scores for each of the health plans. As a reminder, we're calculating risk scores using the Milliman Advanced Risk Adjuster that was approved by the Board in November. We shared preliminary risk scores with the plans in late February.

Over the next several weeks, we'll engage with the plans as part of the rate development process. Each of the plan's final risk scores will be made available at the end of April and shared publicly on the CalPERS website.

Next I want to update the Board and our

stakeholders on our continued important efforts on behavioral health. I want to thank our Board, stakeholders, and members for their input on our work to increase quality and access of behavioral health services for our members. I also want to acknowledge Controller Yee's recent letter on this topic and let you know we remain steadfast in our focus on making sure members have access to the right kind of clinical behavioral health care at the right time.

Dr. Logan, provided an in-depth look at our work on behavioral health in January, but I'll quickly highlight a few key actions underway. Behavioral health is an essential part of our strategic plan. We're monitoring behavioral health claims and utilization, and identifying trends and areas we may need to address with plans. We've seen a significant uptake in the use of behavioral health services during the pandemic, including an exponential increase in the use of behavioral health services through telehealth.

At the same time, we've not noted any increase in grievances and appeals during the same period, which helps to reassure us that our focus over the last few years to improve quality and access is helping our members.

We anticipate that telehealth will continue to play a vital role in behavioral health treatment for our

members after the pandemic and have embarked on a significant research agenda that will be aiding our efforts to harness the best telehealth has to offer, while avoiding some of its downsides.

We continue to work with Covered California and the Department of Health Care Services on a plan to improve behavioral health infrastructure statewide. This we believe will be the key to any truly meaningful change in quality and access.

More recently, we've added behavioral health performance measures to our health plan contracts for 2021. This is just a glimpse of our broad set of activities. Dr. Logan and I will be providing you with regular updates on our work in behavioral health on an ongoing basis. With the continuation of the pandemic and the corresponding rigors and stresses we've all been facing, we're acutely aware of the importance of behavioral health within the CalPERS Health Program.

Last for me, I want to share that this year open enrollment will be held from September 20th to October 15th. These dates are similar to last year's open enrollment time frame. With the various plan expansions and benefit additions you've approved, we'll have our hands full this year.

Dr. Logan is here to provide you with a COVID

update. I can answer any questions now or I can remain -- I can wait until after her remarks. It's at the pleasure of the Chair and the Committee.

CHAIRPERSON FECKNER: Well, we do have a number of questions for you, but why don't we let Dr. Logan go first, because there may be questions in there as well.

CHIEF HEALTH DIRECTOR MOULDS: All right.

CHIEF MEDICAL OFFICER LOGAN: Great. Thank you. Can you hear me?

Yes.

COMMITTEE MEMBER BROWN: (Thumbs up.)

CHIEF MEDICAL OFFICER LOGAN: And good morning. Julia Logan, CalPERS team. It's been a remarkable few months in the fight against COVID-19. Over the winter holidays, we went to -- witnessed a horrific surge in California. Southern California became the epicenter of the pandemic and vaccines were scarce.

Fast forward to today, and more than 12 million Californians have received at least one vaccine dose and our COVID cases have dropped to levels we haven't seen since October.

Over 1,200 providers across the state are administering vaccines. The state expects to have three million vaccines administered a week by the end of March and four million a week by the end of April. President

Biden's $1.9 trillion American Rescue Plan Act will help to accelerate and amplify the state's efforts. The stimulus includes $76 billion for COVID testing and contact tracing, vaccine distribution, and the distribution of other medical supplies.

Earlier this month, Blue Shield of California, under contract with the State as its third-party administrator, launched its centralized statewide vaccination program. Blue Shield will build on the State's existing capacity and vaccination processes that are working well, while enhancing State oversight of the vaccine supply and accountability for all vaccine doses.

Using data-driven targeting of hot spots, Blue Shield has created an algorithm to determine where to allocate vaccines statewide with a focus on equity. The State is directing 40 percent of vaccine doses to disproportionately impacted areas of the state, reserving appointments for members of these communities, and increasing funding for safety-net providers.

Just yesterday, vaccine eligibility opened up to more Californians. In addition to certain essential and emergency workers, and those over 65, individuals ages 16 to 64 with high-risk conditions are now eligible to receive a vaccine. This means that roughly 18 million Californians are now eligible to get a vaccine.

Currently, there are several ways to find an appointment for a vaccine and we recommend that members who are eligible check first with their usual care provider to see if they have vaccines and available appointments.

Providers who have vaccines may also begin reaching out to you to schedule your vaccine appointment. Members can also check their local pharmacies and their local health departments to see if they have vaccines and available appointments. In addition, throughout the Spring, as vaccine supply increases and the statewide vaccinator network grows, you'll be able to schedule an appointment through California's My Turn, their vaccine enrollment website. The website is www.myturn.ca.gov.

And with more than 105 million people across the country receiving highly effective and safe vaccines and COVID cases dropping, questions have come up about a post-vaccine world and what that may look like. Last week, the Centers for Disease Control and prevention released recommendations for fully vaccinated individuals that provide some hope.

According to the CDC, fully vaccinated people can visit with other fully vaccinated people indoors without wearing masks or distancing. They may visit with unvaccinated people from a single household, who are at

low risk for severe COVID-19 disease indoors without wearing masks or physical distancing. They may also refrain from quarantine and testing following a known exposure, if they remain asymptomatic.

While getting shots into arms as quickly as possible is extremely important in getting us back to a sense of normalcy, we are not going to completely eradicate COVID. We will still need to continue to adhere to public health measures, remain vigilant and humble, and we'll need treatments for those who don't respond to vaccines or who haven't yet received a vaccine.

And there's hopeful news on the treatment front as well. New pills to treat patients with COVID-19 are currently in clinical trials, and, if successful, could be ready by the end of the year.

This treatment is a pill designed to do for patients what the drug Tamiflu does for patients with the flu. Positive results were seen in early trials and could prevent hospital stays and help people get better faster.

We realize that for members trying to track vaccine development, eligibility, and supply can be challenging and often frustrating. To keep our members and stakeholders informed, we have been giving regular updates on COVID-related issues at stakeholder meetings and have been keeping information on our CalPERS website

up-to-date.

We also continue to engage with our health plans on COVID-related issues, such as vaccine availability and distribution, as well as ensuring that members get the care that they need in the right settings during the pandemic.

While our health plans do not have direct control over vaccine supply and eligibility, they do play an important role in educating members about the safety and efficacy of the vaccines and in the administration of the vaccine. Our plans are engaging members to provide up-to-date information through direct outreach, vaccine hotlines, and their websites.

OptumRx, our pharmacy benefit manager, has set up a reminder calling system to help remind members that they need their second shot.

Thank you for your time and attention. I'm happy to answer questions. Otherwise, I can pass it back to Don.

CHAIRPERSON FECKNER: Thank you for the presentation. We do have a question for you.

Mr. Miller.

COMMITTEE MEMBER MILLER: I was just curious, Dr. Logan, I noticed there were quite a few reports in the news about local or municipal authorities who were

questioning or kind of balking at participating with, I guess it was, Blue Shield's system. And what were their concerns? And is there anything we should be worried about with regard to that?

CHIEF MEDICAL OFFICER LOGAN: Thank you for the question. I was not aware of the -- their concern. Maybe, Don, if you are aware of it.

CHIEF HEALTH DIRECTOR MOULDS: Yeah. Sure. I mean, I can say that there have been -- there have been some transition complexities is I think the kind way of putting it. You know, the challenge in starting a statewide third-party administrator to centralize vaccine distribution is that you're doing it after vaccine distribution is already started. And so, you know, the Governor had a vision for this that involved building on existing pre-built infrastructure, but also making the process much more uniform.

So that is always going to involve some back and forth between the existing infrastructure, which has largely been county-based, and the -- and the new infrastructure, which is more centralized.

So, you know, you have heard from time to time some of the counties concerned about doing things differently, because they, in their mind, I think, have worked through some of the kinks, and have something that

they see as working. And that's been most of what has been vocalized leads. And I can say just having watched it and talked to some of the folks who are implementing that, you know, the effort here is to take the best of what's built and to implement on top of that some really critical goals. These are the goals to increase the speed of the distribution, goals around the equity of vaccine access, and so forth.

COMMITTEE MEMBER MILLER: Great. Thank you. That's very helpful.

CHAIRPERSON FECKNER: Than you.

Mr. Rubalcava, is your question for Dr. Logan or for Mr. Moulds, because I have a list?

VICE CHAIRPERSON RUBALCAVA: I'll start with Dr. Logan's question -- issue first, and then I have another one later for Mr. Moulds.

Thank you, Mr. Chair.

I want to follow up -- thank you, David, for asking the question, so I'm not going to repeat, but I also understand on the Blue Shield, LA County is one of those counties that is balking as to why they need to coordinate with Blue Shield.

But there was also a lot of news reports that the contract with the State and Blue Shield wasn't clear what the role was, and that it was being amended. So what's --

can you give us a little it, either Dr. Logan or Mr. Moulds, of what is the official role of Blue Shield as third-party administrator or administrator, and what does it entail, because I guess -- I guess one of the concerns was what kind of data were they tracking and sharing, if you could speak to that one, please, somebody.

Thank you.

CHIEF HEALTH DIRECTOR MOULDS: Yeah. Dr. Logan, do you want me to take that one or do you want to --

CHIEF MEDICAL OFFICER LOGAN: Sure, I can start and then if you want to add.

CHIEF HEALTH DIRECTOR MOULDS: Great.

CHIEF MEDICAL OFFICER LOGAN: Yeah. So the role of Blue Shield was really to centralize what's happening in the 58 counties and the other local health jurisdictions, as well as the other providers who are administering vaccines. So there's a lot of accountability that they're doing and oversight that they're doing that wasn't happening in a centralized fashion with the individual counties and vaccine providers.

So they're enhancing the State oversight of vaccine supply and increasing accountability for all of the doses. As you remember, a month or so ago, there was -- there were issues with the amount of doses that

were allocated for the state, but not actually being put into arms. And so those issues with Blue Shield onboard have been resolving and they're able to just be much quicker in kind of their oversight and administration of the doses.

VICE CHAIRPERSON RUBALCAVA: Thank you, Dr. Logan. But if you speak also too, is there a -- is the contract -- have you seen the contract? Is it public? What are your comment -- I mean, because I understood it was not available at first and then it was amended. But I'm not sure what the latest is on the contract between the State and Blue Shield. If you could speak to that question, please.

CHIEF HEALTH DIRECTOR MOULDS: Yeah. We haven't seen a contract, but that's not to say that the contract doesn't exist. We just -- you know, it's not a contract that's involved us. You know, I know that it was -- that the contract was somewhat iterative, so I can certainly -- we can certainly get back to you as to where it stands right now. But, you know, it's been a -- it's been a -- they've, you know, started this very quickly, moving very quickly. And it's -- you know, it's been reported out in, you know -- in fits and spurts, but certainly happy to get back to you with the answer to the question of sort of what's public out there right now with respect to the

contract.

I can tell you, you know, just to reaffirm what Dr. Logan says, is that, you know, one of the key roles that Blue Shield is playing right now is this oversight role, which is really critical. They've -- they have been moving vaccine from places where distribution has been slower than it should be to places where it's more -- it's quicker. They've been moving it to address some of the -- of the equity issues. So certainly on the supply side, they're playing a very major role.

VICE CHAIRPERSON RUBALCAVA: Thank you. Thank you, Mr. Moulds. And Ms. Ortega just, on the chat, shared the contract. And actually I was looking at the scope of work. So thank you very much, Ms. Ortega. Thank you, Mr. Moulds.

I do have a question after, Mr. Feckner, when we get to -- off the COVID issue. Thank you.

CHAIRPERSON FECKNER: Very good.

I think that's all for you Dr. Logan. I will go back to the questions for Mr. Moulds. First, I have Ms. Greene-Ross.

ACTING COMMITTEE MEMBER GREENE-ROSS: Thank you. And thank you, Mr. Moulds and Dr. Logan, the Controller's concern was just about everything we've been hearing and reading about the escalation in COVID's second impact on

mental health, besides the fiscal impacts, just seemed excessive from everything we've been reading and hearing. And we know the team has been working on it, so appreciate just having regular updates. And if you are able to share what sort of performance metrics you're putting on our plans, that would be helpful to know, so we can see how we're going to track that. Much appreciate that.

And my second comment, we were contacted from several folks about -- on the Long-Term Care Program rate adjust -- changes and the impacts of COVID. So I appreciate the update about that, and that you'll obviously -- it will be -- remain to be seen if there's any sort of long-term impacts. And appreciate that you will be considering that for the second round of rate increases. So thank you.

CHAIRPERSON FECKNER: Thank you.

Ms. Brown.

COMMITTEE MEMBER BROWN: Thank you, Mr. Chair and congratulations. My question is also on long-term care. I have heard from a number of members about the rate increases and sort of the process by which we are giving them specialized rates, so maybe their rates don't increase as much, or at all. Can you tell me, Dr. Moulds, about how many or what percentage of the insureds you've heard from about tailored offers or tailored efforts? I

mean, is it half, all?

CHIEF HEALTH DIRECTOR MOULDS: We've heard from very few. We -- very few -- episodically at this point, we've gotten contact -- we received contact from policyholders about their rate increases, largely and certainly understandably, expressing frustration over the fact that we need to raise rates. We -- the process for the rate increase, you know, while we've been put -- we've been putting up information on our website. We've been talking with the stakeholders who, in turn, have been sharing information in their news letters. But, you know, we expect that a good percentage of the -- of the -- of the policyholders are probably at this point unaware of the forthcoming rate increase.

We send -- in a few months, we will be sending out letters former -- formally letting them know. Those are ahead of the offer letters that I mentioned that will give them their buydown options. But the buydown options are where we would expect, and them to engage, with Long Term Care Group in working through customized approaches, if that's what they choose to do. That's historically been the experience.

So in terms of, you know, percentages of policyholders who would be seeking some sort of customized approach, it's really too early to tell. I can tell you

historically, just looking back at the last rate increase, it was a relatively small number of policyholders. The vast majority either took the rate increase or took the offer that we -- that we sent in the offer letters, which is part of the reason that we wanted to make sure that the offers were thoughtfully constructed and tailored to the specific policies of the beneficiaries.

COMMITTEE MEMBER BROWN: I appreciate that. My concern is that I wanted us to be noticing the members sooner rather than later. I know we have a legal obligation by the contract in terms of how many days in advance we must notify them, but I really want us to notify them early enough, so they can start planning, and maybe making different choices once they realize that their policy could be going up, you know, 50 percent, 80 percent, whatever the percentages are. And so I just want us not to wait till the last minute to notify them.

CHIEF HEALTH DIRECTOR MOULDS: Yeah. So I'll just -- I'll just say I completely appreciate that. I did not want to send a letter to our policyholders about a rate increase until we had nailed down the exact date of the rate increase. The last thing I want to do is give them partial information or information that may be subject to change. So we had looked at sending the letter earlier in the spring to notify them of the future rate

increase, but I held that, because I wanted to wait until we had specific information that was -- that was hard -- with hard dates.

COMMITTEE MEMBER BROWN: So thank you.

Are we going to do a new actuarial study based upon sort of the changes in uses of long-term care or the number of people who've passed away, who maybe are no longer on our Long-Term Care Program? And the reason I'm asking -- I'm asking that we do that is just like we've done for the East San Gabriel Valley people with their pensions, we did another actuarial study to make sure we could give them the most pension or give them the least amount of reduction. I'd like us to do the same with the long-term care, that we seriously look at that, and maybe even hold off on increases this time around, until we get that additional information, you know, to us and the stakeholders.

I'm telling you people are -- a hundred thousand or so members are very, very concerned about what they're going to be doing in the future.

CHIEF HEALTH DIRECTOR MOULDS: Sure. Yeah. We do -- we run an actuarial report looking at the -- everything from the state of our returns to our -- to our mortality, morbidity, and lapse rates, and update our assumptions in the Long-Term Care Program on an annual

basis. That's -- that work is led by the Actuarial team. So we will -- that will be done before we implement this coming rate increase.

I can tell you that we've been -- you know, when I say that we've been monitoring for the possibility of changes in our liabilities due to COVID, you know, we -- we have data from the spring surge that just didn't show meaningful differences in mortality or claims. We -- I speak with Long Term Care Group that sees claims coming through as they come through. We have not seen -- I spoke with them last week. I spoke with them two weeks ago. We have not seen meaningful changes there. The one place where we might be more likely to see changes is in -- is in mortality. And, you know, a lot of our policyholders are billed on an annual basis, so lapse -- lapses due to mortality may not -- may not be things that we see until the next -- the next billing cycles.

When I checked with our actuarial team a week ago, as I'm doing with them also about mortality, they are still not seeing meaningful difference, but that's not to say that it won't happen.

You know, the risk in delaying the rate increase is that the longer we delay the rate increase, the more of a rate increase we have to implement. So as we -- every month that we're not putting forth the rate increase is a

month where we're not collecting the additional premium and it increases our liability. So you know, it is something that we're paying close attention to, because if there are significant changes, we're going to want to make the adjustments. But it also wouldn't make a lot of sense to put off our rates significantly, because ultimately when we do -- when we do the rate increases, we'll just need to go forward with higher rate increases. And that's something that I think none of us want to do.

COMMITTEE MEMBER BROWN: Thank you for that, Dr. Moulds. I have an accounting and finance background, so I do know that putting it off, you know, budget cuts or, you know, increases do delay and cause greater harm later.

The question about the mortality and the billing being annually, can we look at that ahead of the annual billing? I mean, I know we get -- sorry to say, we get a death roll from the Social Security or we get it from someone. Can we use that in order to look at mortality instead of waiting for the annual billing cycle?

CHIEF HEALTH DIRECTOR MOULDS: So some of it we will see -- some of it we can see that way. We can't look at our own data, because this is a completely different population than the CalPERS membership, so it --

COMMITTEE MEMBER BROWN: Okay.

CHIEF HEALTH DIRECTOR MOULDS: -- would be -- a

minority of long-term care policyholders are actually CalPERS members. So, you know, we can't get accurate data looking at our own records that way.

COMMITTEE MEMBER BROWN: I appreciate your answers. And I just hope we're -- it sounds like we're doing everything we can to stave off huge increases to our long-term care members.

And then, Mr. Feckner, I know that there are a couple of callers on the line who'd like to talk to Dr. Moulds. I don't know if you're going to let them go out of order, but hopefully you'll let -- you'll call on them when all the Board members are done asking their questions. Thank you.

CHAIRPERSON FECKNER: They are on the list as soon as we're done hearing from Committee and Board members.

COMMITTEE MEMBER BROWN: Thank you.

CHAIRPERSON FECKNER: Next, I have Mr. Rubalcava

VICE CHAIRPERSON RUBALCAVA: Thank you, Mr. Chair. Mr. Don, I had -- Moulds, I had a question on the behavioral health. First, I want to also join -- thank Controller Yee for her advocacy on this issue.

Mr. Moulds, you mentioned that you -- there were some efforts underway to work with some other parties to improve the behavioral health infrastructure. Can you

expand on how that will be done, because at least for most of our members, it's through their medical plan who provide that service.

CHIEF HEALTH DIRECTOR MOULDS: Yeah.

VICE CHAIRPERSON RUBALCAVA: So they contract with -- either the have it in-house, like I say Kaiser does, or they contract with other providers, the insurance companies. So how would that -- what are you looking at?

CHIEF HEALTH DIRECTOR MOULDS: Yeah.

VICE CHAIRPERSON RUBALCAVA: I mean, independent carve-outs or something like that. I'm just curious.

CHIEF HEALTH DIRECTOR MOULDS: No. The mention of -- the mention of Covered California and Department of Health Care Services was -- you know, so basically what we're doing is the -- so combined, I've said this before, but, you know, the three -- the three of us, CalPERS, Covered, and Medi-Cal comprise more than half of the total non-(inaudible) lives in California. We're 16 million strong across the three of us, which gives us tremendous leverage in the marketplace.

And one of the -- you know, we all -- we all use many of the same providers in our networks. And the challenge historically is that we've all been asking those providers to do different things. We've measured their successes in different ways. And so you have providers

that row one direction for Covered California, a different direction for Medi-Cal and so forth. And there's tremendous power in identifying the right metrics and then all askin for the same thing. If you have more than half of the -- of the purchasing power in California asking providers to do exactly the same thing, it's far more likely to happen.

So that's part of it. Part of it also is thinking about larger efforts to expand the workforce. You know, this is an area that's challenged. Part of it is pooling our resources to understand better how to maximize the use of telehealth in productive ways. So, you know, as Dr. Logan has said before and as I've said before, telehealth is a real winner for behavioral health. There's a lot of evidence that suggests that lots of people who are uncomfortable getting in-person behavioral health services will use telehealth to get those services.

It's also challenging because particularly in rural areas behavioral health services are often not available or they're really hard to get to. So you have to drive a long way. If you're doing it regularly, that creates challenges. So, you know, aligning with Covered California and Medi-Cal and focusing our efforts in the same direction is going to lift all boats and we think improve behavioral health services for all of our

enrollees, or members, and so forth.

VICE CHAIRPERSON RUBALCAVA: Mr. Moulds, I thank you for taking the initiative to work with other partners especially this big to try to improve the access for everybody. So I thank you for that.

CHIEF HEALTH DIRECTOR MOULDS: Yeah, you're welcome.

VICE CHAIRPERSON RUBALCAVA: I do have one -- I do have one more question on something else. In your report on risk mitigation, you're talking about the sharing of risk scores. While risk scores and the risk pool is a big element in what we're trying to figure out how best to -- what are the most appropriate way to arrive at justified premium rates, the COVID situation has also impacted utilization, reduced it in many areas. And so I wonder how that -- how would that counterbalance the risk scores? I mean, wouldn't that be sort of -- I mean, in a way it's sort of mitigated the risk pool, didn't it?

So I was wondering if we -- how we're preparing to deal with that issue about COVID utilization -- COVID impacting utilization in a favorable way. How would that --

CHIEF HEALTH DIRECTOR MOULDS: Yeah. You know --

VICE CHAIRPERSON RUBALCAVA: -- how would that play on the rate calculations?

CHIEF HEALTH DIRECTOR MOULDS: Yeah. That's -- so that's a great question. I don't want to get too granular, but you asked a granular question, so forgive me.

(Laughter.)

CHIEF HEALTH DIRECTOR MOULDS: But the way that -- the way that -- the way that risk scores are developed is that typically the entities that develop them identify conditions or use patterns that are -- that are essentially proxies for future increased risk. So COVID -- COVID -- because COVID is more of a point in time, COVID is -- would not be one of those conditions. It doesn't mean that COVID isn't a confounder when it comes to risk scores, or that there isn't overlap. Because as you know, having say diabetes or obesity is a -- is a risk factor for COVID, and -- you know, and potentially used in risk scores, especially diabetes.

So they're different, but COVID -- you know, COVID is -- as I said, it's a confounder that we've talked to Milliman about how they account for COVID. They have looked primarily at data pre-COVID, so 2019, in development of some of their risk scores. And then they try to disaggregate COVID out of it. So you would presumably discount for things like -- or you would pull out things like hospitalizations related to COVID, because

hopefully they are not indications of future medical liabilities.

VICE CHAIRPERSON RUBALCAVA: Thank you.

CHAIRPERSON FECKNER: Thank you, Mr. Moulds. I do want to say that these are some pretty deep topics for executive report, so can we look at putting these on a future agenda item to discuss the behavioral health and mental health issues with the different plans, et cetera, as well as risk mitigation.

CHIEF HEALTH DIRECTOR MOULDS: Sure. Point taken, and happy to.

CHAIRPERSON FECKNER: Very good. Next, I have Ms. Ortega.

COMMITTEE MEMBER ORTEGA: Thank you, Mr. Chair. I just wanted to say that the Blue Shield contract is available on the public website of COVID-19.ca.gov for those listening.

CHAIRPERSON FECKNER: Excellent. Thank you.

I have Mr. Jones.

COMMITTEE MEMBER JONES: Thank you. First of all, congratulations to the Chair and Vice Chair on your reelections.

And my questions to Mr. Moulds. I did hear that you said that -- I think I heard that the letters will be -- on Long-Term Care Program, the letters will be

mailed out in August, but I didn't hear the deadline date. And also when the member select an option, is the effective date is when their election is received or is all members going to be modified on the same date at some deadline date?

CHIEF HEALTH DIRECTOR MOULDS: Yeah. So both good questions. The letters -- the letters in August are the offer letters. There will be a letter that predates that letter just informing members of the rate increase. But the offer letters are the ones that require the customized use of the decision tree, so they really can't go out any sooner.

The vast majority of -- so billing, because this is such an old program dating back to the -- to the nineties, the billing cycle structure is different for different members. Most of the -- most of the bills will go out in November. We anticipate about 80,000 -- actually, a little over 80,000 of those bills would go out right away in November. So some bills, because of other reasons they're on a different billing pattern, would go out a little bit later. But as I said, the vast majority in November.

COMMITTEE MEMBER JONES: So is there a deadline date in which a person could exercise their options?

CHIEF HEALTH DIRECTOR MOULDS: So they have --

they have 60 days to exercise their option.

COMMITTEE MEMBER JONES: Sixty days from receiving the letter.

CHIEF HEALTH DIRECTOR MOULDS: Correct.

COMMITTEE MEMBER JONES: Okay. Thank you.

CHAIRPERSON FECKNER: Thank you.

Mr. Miller.

COMMITTEE MEMBER MILLER: Yeah. Yeah, Mr. Moulds, I just -- kind of an observation and it may be a little premature for us to really be thinking a lot about this, but kind of you mentioned the -- you know, kind of post-COVID world, where we see, for example, in long-term care, that maybe the people being more comfortable going back to it, or also with health care in general, I think a lot of people may be deferring care, or deferring procedures, or that -- that may seem like a short-term savings, you know, or -- but really for people with chronic conditions, avoiding health care, you know, may impact usage, and cost in a negative way in the future.

But one of the things I kind of wanted to bring up and point out is, while there is some real common impacts between say long-term care and acute care, or even, you know, almost anything in health care where they've had to invest a lot in capital costs, infrastructure changes, everything from facilities to HVAC

in existing facilities and everything because of COVID, the impact of those costs on their business models and finances may not appear to us via providers, or insurance, or our negotiations for a while.

And even things like right now the labor costs. In California, the cost of agency nurses recently exceeded $200 an hour. And I know it's been a really huge challenge and concern, because they've had a lot of capacity issues with their workforce.

But in contrast in long-term care, their challenge is -- and it's an industry that's nearly in crisis, because they do not have the kind of financial structures to be able to, for the most part, balance pair mix, and the different margins of their different service lice, because they have very few. And a lot of them, you know, are potentially going to be blinking out rather than recovering. And I think that's something in a kind of a longer, you know, one to five year should -- is going to impact us and impact our members, and it's going to be of great concern, so --

CHIEF HEALTH DIRECTOR MOULDS: Yeah. So great point -- great points, I should say. You put your finger on a number of issues that have -- that have sort of popped into my head in the middle of the night and kept me awake. The -- you know, it is one of -- it is -- I would

say the main -- I will say this first, I'm extremely worried about the future environment for long-term care for many of the reasons that you just identified, but also because of a lot of regulatory uncertainties.

As we -- rightly so, as we think about the future -- the future for long-term care facilities, in the interests of avoiding the kind of mortality that we saw over the last year in long-term care facilities, I cannot imagine not seeing new requirements about spacing, and ventilation, and all of the kind of things that you mentioned.

And we also know that there's going to be massive consolidation in the industry. And as we know, that's never a good thing on price. So, you know, this is -- this is the reason that we are moving forward on the aging-in-place strategy, which is also a managed care strategy, and is also what we are hoping to put in front of our policyholders to avoid some or potentially even all of the second year rate increase.

You know, the winner for everybody in this kind of environment is providing options for people to age in their own homes, to decrease the pressure on facilities going forward, and -- and to improve, you know, our future financial picture at the same time.

So that's where we're headed to address some of

these challenges. But I think you're right in having concern about them. I certainly do as well.

COMMITTEE MEMBER MILLER: Yeah, I'm -- I don't want to say I'm glad that it's keeping you up at night, but I'm glad that as usual, you and Dr. Logan and the whole team are, you know, really on top of all this, and that we're thinking beyond just the immediate circumstances. So thank you for that.

CHAIRPERSON FECKNER: Thank you.

Mr. Ruffino.

ACTING BOARD MEMBER RUFFINO: Thank you, Mr. Chair. And first, congratulations to you and the co-chair on your election.

A mental health crisis was looming even before the pandemic hit and now more than ever I think our members need more support and more resources than ever before. So the Treasurer is requesting CalPERS to perhaps schedule, and has been said, another hearing in the near future regarding the access of mental health and get an update, you know, for all the health care providers, as we did a year ago, and to see where are we at.

And so I just wanted to ensure, you know, that we made that request to you, Mr. Chair, and to -- and to the Committee. Thank you.

CHAIRPERSON FECKNER: Thank you, Mr. Ruffino, and

thank you to Ms. Ma as well. We've also had that same request from Controller Yee, Mr. Rubalcava, and a couple other Board members. So Mr. Moulds knows that he's going to put that on a future agenda, and we're going to tackle that issue.

Seeing no other requests from the Board to speak at this time, Mr. Fox, I understand we have a couple of folks that wish to speak from the public.

STAKEHOLDER RELATIONS CHIEF FOX: Yes, Mr. Chair. We have two callers for Don Moulds -- comments to Don Moulds, Mr. Tim Behrens from CSR.

MR. BEHRENS: Good morning. Can you hear me?

CHAIRPERSON FECKNER: Good morning. We can hear you just fine.

MR. BEHRENS: Thank you. This is Tim Behrens, California State Retirees. Congratulations Mr. Feckner, Mr. Rubalcava. Thank you for the opportunity to comment.

I want to address the long-term care insurance decisions this Board approved in November. We appreciate Dr. Moulds willingness to delay the implementation date of premium increases in order to offer another option to subscribers to mitigate premium increases. I would point out, however, that in order to have no increase, a member would need to select options which would significantly reduce the value by close to 50 percent of their coverage

after many have reduced coverage for past premium increase amounts.

Case in point, one of our CSR members who purchased long-term care insurance at its inception for he and he wife, out of concern for their later years. In 2013, they chose to reduce their benefits to ten years with no inflation protection, and still their premiums rose to $227 per month each. In 2019, their premiums increased to $448 per month each.

The actions you approved in November will raise their premiums to $851 each. To mitigate that, they would have to reduce their coverage to what they may consider unacceptable levels. A likely outcome for them and many others will be terminating or letting their policies lapse.

They will lose all of the thousands of dollars they had prudently, they thought, paid to protect their assets, if they needed long-term care. Ironically, higher lapse rates are likely the result of the 90 percent increase over two years, will actually help the fund, since it will retain all contributions and not have to pay claims for those subscribers.

In November, CSR expressed concerns over the rate increases and benefit reductions, but stayed neutral on the proposed actions, because we understood the challenges

the fund and CalPERS faced.

In light of new information, however, we now oppose this large increase and ask that CalPERS to further evaluate and reconsider the need for any increase, and certainly not 52 percent this year. This new information is from various sources, which Larry Woodson ill detail for you in his comments. They include large savings due to the COVID pandemic, better than expected long-term care investment returns, and many uncertainties about future nursing home usage.

Larry's sources include long-term care commercial providers, quarterly reports, industrial analysis reports on COVID pandemic effects, and the American Academy of Actuaries report titled Impact of COVID-19 on Long-Term Care Insurance.

Larry has requested five minutes to present this complex data. I hope the Chair will grant the extra two minutes. Thank you. Have a good day and stay safe.

CHAIRPERSON FECKNER: Thank you, Mr. Behrens.

Mr. Fox.

MR. WOODSON: Hello.

CHAIRPERSON FECKNER: Hello.

MR. WOODSON: Hello.

CHAIRPERSON FECKNER: Hello.

MR. WOODSON: Hello. Can you hear me?

CHAIRPERSON FECKNER: We can hear you.

MR. WOODSON: You can hear me?

CHAIRPERSON FECKNER: Yes.

MR. WOODSON: Okay. Thank you. Mr. Feckner, congratulations, and to Mr. Rubalcava as well. Am I able to speak for five minutes?

CHAIRPERSON FECKNER: Yes.

MR. WOODSON: Okay. Thank you.

First of all, I'd like to say that Dr. Moulds addressed a number of issues that I'm going to raise, but I do feel that I have some disagreement with some of his statements.

So let me start by saying as of March 10th, 54,621 Californians have died from COVID-19, 12,905 of those, or 24 percent, were in nursing homes. The mortality rate alone represents a cost decrease for LTC insurers over the last year. A breakdown by funding type isn't available, but Medicaid patients would likely be higher. But I have found cost savings from numerous commercial LTC insurers, which would be most similar to our CalPERS claimant population.

One carrier group, Unum Group, announced claimant mortality increased by 30 percent in their second quarter, yielding a positive quarter. And I apologize for that characterization. And they described new claim incidents

also as favorable, meaning lower, driven by what they believe is a hesitancy toward nursing homes.

American Enterprise reported operating earnings of 17 million, a big increase for their second quarter in its long-term care segment, based on a drop of policyholders entering nursing homes and increased mortality-related terminations.

Genworth Financial also saw terminations significantly higher in second quarter. One analyst, Piper Sandler states quote, "The need for LTC rate increases may be actually greatly reduced". Another analyst, and Andrew Kligerman says he expected the lower claim levels to continue the rest of the year. Also not mentioned yet is the disproportionate number of COVID deaths among the elderly not yet in need of LTC will contribute to fewer claims in the short to mid-term.

Note that this information comes from carriers second quarter reports, well prior to the enormous mortality spikes since.

Lastly, according to the American Academy of Actuaries Report, economic conditions and fear of LTC facilities may cause short to longer term lapse rates of policyholders. Higher lapse rates equal lower cost for carriers. The combination of all these factors brings significant cost relief in the short term, likely much

longer. And as Don said, none of this COVID information was considered or available to CalPERS when completing its latest actuarial valuation report on which it based its two-year 90 percent premium increase -- compounded to 90 percent. Even now, COVID data specific to our subscriber population is limited, due to the six-month data lag that done mentioned.

So while some industry analysts predict cost increases in the long term and a return to normalcy, the Academy of Actuaries report actually suggests that lower costs may continue. There's great uncertainty, but income and -- or increase in home health, which is half the cost, may be the outcome.

So finally, I want to cite important additional data. None of the six LTC agenda items analyzed for September and November committee meetings, while painting a bleak picture of investment returns, reported this figure that I found on page four of the full 62-page actuarial report. Quote, "The program experienced an investment return of 7.1 percent during FY 18-19". Remarkably, that's nearly two percent above the 5.25 discount rate, which you just lowered, which largely contributed to the 90 percent increase.

One final figure the Board members may not be aware of, during our March 3rd retiree roundtable, I

learned from Dan Bienvenue that the most current status of the LTC fund total assets now stands at 5.3 billion dollars. It's a 12 percent increase over the 4.73 billion in assets in that report, on which these increases were based.

We urge CalPERS to delay any increases in premiums till staff can accurately evaluate the COVID impacts, the influence of a much higher total fund assets, and reevaluation of the need to lower the discount rate based on a 7.1 percent recent return.

Thank you.

CHAIRPERSON FECKNER: Thank you.

Seeing no other requests to speak on this item, Mr. Fox, was there anyone else on the line?

STAKEHOLDER RELATIONS CHIEF FOX: Mr. Chair, no that's concludes public...

CHAIRPERSON FECKNER: Very good. Thank you.

Before we go on to the next agenda item, I just want to note for the record that Ms. Westly has joined the Committee. So welcome this morning, Ms. Westly.

That brings us to Agenda Item 5, action consent items. Having no requests to move anything, what's the pleasure of the Committee?

COMMITTEE MEMBER TAYLOR: Move approval.

CHAIRPERSON FECKNER: Is there a second?

VICE CHAIRPERSON RUBALCAVA: I'll second. Ramon Rubalcava.

CHAIRPERSON FECKNER: There was a motion by Ms. Taylor seconded by Mr. Rubalcava. Any discussion on the motion?

Seeing none -- oh, Ms. Brown.

COMMITTEE MEMBER BROWN: Yes. I'm sorry. Can you -- can you help me which items were voting on. My Diligent went down. Five -- action consent item is 5A, the approval of the November 17th committee meeting minutes; 5B review of the Pension and Health Committee Delegation; 5C, minimum standards for health benefit plans amendment of regulations.

COMMITTEE MEMBER BROWN: So I need to 5C broken out separate. I'm going to vote on it.

CHAIRPERSON FECKNER: Okay. We'll take up items 5A and 5B as part of the original motion.

Any other discussion on the motion?

All right. We're voting 5A and 5B as action consent items. Ms. Hopper.

COMMITTEE SECRETARY HOPPER: Margaret Brown?

COMMITTEE MEMBER BROWN: Aye.

COMMITTEE SECRETARY HOPPER: Henry Jones?

COMMITTEE MEMBER JONES: Aye.

COMMITTEE SECRETARY HOPPER: David Miller?

COMMITTEE MEMBER MILLER: Aye.
COMMITTEE SECRETARY HOPPER: Eraina Ortega?
COMMITTEE MEMBER ORTEGA: Aye.
COMMITTEE SECRETARY HOPPER: Ramon Rubalcava?
VICE CHAIRPERSON RUBALCAVA: Aye.
COMMITTEE SECRETARY HOPPER: Theresa Taylor?
COMMITTEE MEMBER TAYLOR: Aye.
COMMITTEE SECRETARY HOPPER: Shawnda Westly?
COMMITTEE MEMBER WESTLY: Aye.
COMMITTEE SECRETARY HOPPER: Karen Greene-Ross for Betty Yee?
ACTING COMMITTEE MEMBER GREENE-ROSS: Aye.
COMMITTEE SECRETARY HOPPER: Mr. Chair, I have a motion made by Theresa Taylor, seconded by Ramon for items 5A and 5B, all ayes.
CHAIRPERSON FECKNER: Thank you.
That brings us to 5C. We'll have the same motion and seconder.
Ms. Brown, did you want to speak to it before we vote?
COMMITTEE MEMBER BROWN: No, I'm fine just voting no. Thank you.
CHAIRPERSON FECKNER: All right. Ms. Hopper.
COMMITTEE SECRETARY HOPPER: Margaret Brown?
COMMITTEE MEMBER BROWN: No.

COMMITTEE SECRETARY HOPPER: Henry Jones?
COMMITTEE MEMBER JONES: Aye.
COMMITTEE SECRETARY HOPPER: David Miller?
COMMITTEE MEMBER MILLER: Aye.
COMMITTEE SECRETARY HOPPER: Eraina Ortega?
COMMITTEE MEMBER ORTEGA: Aye.
COMMITTEE SECRETARY HOPPER: Ramon Rubalcava?
VICE CHAIRPERSON RUBALCAVA: Aye.
COMMITTEE SECRETARY HOPPER: Theresa Taylor?
COMMITTEE MEMBER TAYLOR: Aye.
COMMITTEE SECRETARY HOPPER: Shawnda Westly?
COMMITTEE MEMBER WESTLY: Aye.
COMMITTEE SECRETARY HOPPER: Karen Greene-Ross for Betty Yee?
ACTING COMMITTEE MEMBER GREENE-ROSS: Aye.
COMMITTEE SECRETARY HOPPER: Mr. Chair, I have the motion being made by Theresa Taylor, seconded by Ramon Rubalcava, all ayes, one no made by Margaret Brown on Agenda Item 5c, minimum standards for health benefits and plans, amendment of regulations.
CHAIRPERSON FECKNER: Thank you, Ms. Hopper.
Brings to us Item 6, information consent items. I do have a request to withdraw -- pull off 6C for further discussion.
So at that point, we're on 6c to discuss. Ms.

Taylor, please.

COMMITTEE MEMBER TAYLOR: Thank you. I just wanted to have Mr. Moulds, or whomever, to talk about the movement between plans what the -- kind of what the results were, I mean, I've got the table here, and I know we've all got the table. What were the drivers of these movements, if you don't mind?

CHIEF HEALTH DIRECTOR MOULDS: I mean I can -- I can tell you at a high level. And I have Karen Páles, who is the over Acting Division Director overseeing HPRA here for specific questions. But as a general rule, we saw -- you know, we saw some movement, but not substantial movement, which is pretty par for the course, both with CalPERS and with health insurance generally. We've -- I mentioned this to Mr. Jones in the past, but, you know, we've done a little bit of work. We've had a researcher from Cal looking at our members who are even more, and the term of art is sticky. So people at CalPERS -- people generally tend to stay with their health insurance. People at CalPERS even more so.

You know, we're looking at some of the reasons why, because ultimately we want to see our members shop. In any particular area, it's often the case that there's a better deal out there. And we're forever trying to bring better deals into the various region. But part of having

that be significant is having people take them up.

So, you know, it's a hard nut to crack. Having the options is important. But CalPERS members tend to stay with their plans, unless there are pretty significant changes in pricing.

COMMITTEE MEMBER TAYLOR: Okay. It looks like -- I appreciate that, Mr. Moulds. It looks like it was kind of a lot of movement, based on what I'm seeing here. So, for example, it looks like the PERS plans, there was a lot -- quite a bit of movement. I imagine that was cost.

CHIEF HEALTH DIRECTOR MOULDS: Yes.

COMMITTEE MEMBER TAYLOR: The other plans though -- and I don't know if it's because we had different choices, there was -- there seemed to be a lot of movement out of and into different plans. And I -- so you're -- so what -- basically, what you're saying is is most of it is cost drivers.

CHIEF HEALTH DIRECTOR MOULDS: Yeah. I mean, not -- candidly, not as much as we would assume, given price differences. We certainly have seen some. But Karen, do you have anything you want to add there.

HEALTH POLICY RESEARCH ACTING DIVISION CHIEF PÁLES: Ms. Taylor, Karen Páles, CalPERS team member. You know, it's actually very interesting that the percent -- the overall percent of change was lower in 2020 than in

previous years. I went and took a look after we spoke with Mr. Rubalcava, and in 2017, it was close to give percent overall movement, in '18 about six and a half, in 2019, almost five, and then for 2020 only 3.1 percent. So actually had less movement during the 2020 open enrollment than in the last couple of years.

And as you saw on the table, the plan that gained the most members was the PERS Select. And so, if -- it feels a little bit like that's not wanting to be the first ones to jump into the new plan design, right? After they see it in action for a little while, we have a little bit more movement into that plan.

But as Don mentioned, our members are very sticky. We have a hard time getting folks to recognize the value of a plan change for them. People tend to stay with what they have. We've never really seen big movements. And it actually was a little bit less movement than we've seen in the last few years, if that helps.

COMMITTEE MEMBER TAYLOR: Okay. Great. I just kind of wanted to highlight that for our stakeholders a little bit, because we talk about -- we do talk about it every year, but we don't get into the granular part of it. So I appreciate it. Thank you so much.

HEALTH POLICY RESEARCH ACTING DIVISION CHIEF PÁLES: You're welcome.

CHAIRPERSON FECKNER: Thank you.

That brings us to Agenda Item 7, action agenda items, competition study. Mr. Moulds.

CHIEF HEALTH DIRECTOR MOULDS: Great. Good morning, again, Mr. Chair and members of the Committee. Don Moulds, CalPERS team.

Item 7A is a culmination of work we've been talking with you about for a while now. It's a competition model for our basic health plan portfolio. We embarked on this work to provide data and information to guide CalPERS decision making in determining the right mix of plans for optimal competition across our various regions. As we've discussed before, the right mix of plans and plan types can maximize competition among insurers, as well as between insurers, and providers which can lower prices, and the wrong mix can have the opposite effect, driving up prices.

Last year, we engaged Leemore Dafny, professor of Business Administration at Harvard Business School, and academic affiliate at Bates White Economic Consulting, to build CalPERS an economic model that predicts the impacts of changes in basic plan offerings on overall health plan premiums. The competition model anticipates member migration among plans, competitive dynamics within geographic areas, and overall impacts on regions as well

as statewide.

What we've been referring to as the competition study is an economic model that was finalized in January and that the CalPERS team has used this year in our valuation of health plan proposals. We've also been using it to better understand the competitive dynamics in our basic plan portfolio generally, both to think about what types of new plans or plan expansions we may solicit in the future, and in anticipation of our next health plan contract cycle, which will culminate in new plans and plan renewals that will become effective January 1st, 2024. Preparations for that cycle will begin later this year shortly after your approval of the 2022 rates.

By way of reminder, at the November PHBC, we presented several new plans, service area expansions, and benefit design proposals for 2022. The Board approved all of the team's recommendations, but for three of them the approval was contingent upon confirmation that the competition model, at that point still under development, affirmed that the net effect of the proposals was that they would improve competitive dynamics and ultimately create downward price pressure.

In November, we indicated that we would be bringing that analysis back to the Board in March, which is what we're doing today. In addition to the plans that

you approved, provisionally or outright, in November, we briefly discussed one additional new service area expansion that was submitted just under the wire. That proposal was put forth by Western Health Advantage. They are proposing to expand their basic HMO plan into Humboldt County. Because that proposal was submitted too late to bring to you formally in November, we only alerted you to it. We didn't ask you to approve it. So I'll be returning to it later in this presentation and will be asking you to approve it formally.

With that, I'll turn things over to Dr. Dafny, who as you may recall joined us for the Board off-site last July. Dr. Dafny is the Bruce V. Rauner Professor of Business Administration at Harvard Business School and serves on the faculties of the Harvard Business School and the Kennedy School of Government. She's a leading expert on competition and U.S. health care markets. Dr. Dafny is going to share a little more about the model she built with her colleagues at Harvard and Bates White, as well as key findings.

Following her presentation, I'll walk you through the findings of the competition model as they relate to the three plan expansions you tentatively approved in November, as well as the proposal to expand Western Health Advantage into Humboldt County.

So I'll turn it over to Dr. Dafny.

(Thereupon a slide presentation.)

DR. DAFNY: Hi. Well, good morning to you. Good afternoon over here. Thank you, Dr. Moulds, Chair of the Board and Board members for inviting me to speak today. The first couple of slides I have here are basically just to refresh where we were when I last spoke to this group in July. So the next slide --

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DR. DAFNY: -- gives a bit of information about the background for this study. So CalPERS approached me back in fall 2019 to ask if I could help develop a model to assist in developing and refining plan offerings. My expertise is competition and health care markets. And Dr. Moulds expressed a particular interest in understanding how CalPERS could, through its plan offerings, potentially spark more competition among providers and insurers, In order to serve your members and generate greater value for them.

As I mentioned in July, I asked an economic consulting firm, Bates White, to assist me with this project. Through them, we added two excellent economists, Robin Lee, a colleague at Harvard's Economic Department and Zenon Zabinski, who is a principal at Bates White.

Next slide.

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DR. DAFNY: All right. So tho goals that we agreed upon, after a little big of back and forth, was -- are listed right here, right?

First of all, we needed to understand and model all of the moving pieces, how they come together to generate enrollment premiums and value. I'll use the term "utility". Economic utility is just an index of consumer satisfaction for members. And once we had built the model, we took it out for some rides, which we formally call simulations and we did that. We modeled both historical changes to see how well our plan -- our model predicted them and also feature changes in order to assess what might happen under alternative scenarios. And those scenarios, as Dr. Moulds mentioned, included the specific expansion proposals that are going to be discussed in a couple of moments. But we really tried to focus as well on using the model to develop some broader insights. And I should note that the model itself incorporates CalPERS plan to changes as relevant, including risk adjustment.

So the next slide --

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DR. DAFNY: -- gives you a sense for the study design. And where we were in last July was in the data step. There's quite a lot of data, de-identified, that we

utilized in stage one to build what we call a choice model, where we use data on the choices -- actual choices of members, member characteristics, including, of course, location, but also family, also risk scores, and plan characteristics to drive -- you know, to figure out the drivers of the choices that they were made.

And I should note the plan that you chose last year is also a relevant predictor as has been discussed earlier today. There's a lot of inertia. So that's reflected in there. And we tested and refined the model by comparing predictions of the model to actual choices, for example using the data from 2014 to 2019, to estimate the model predicting what happened to enrollment in 2020. And we did pretty well in terms of making those predictions.

All right. And then the next stage, stage two in orange here.

Oh, not the next slide. Sorry.

It's the next stage, stage two in orange, we estimated a model of plan costs, medical and pharmacy costs, which depend on characteristics of the enrollees in particular their risks scores, also regional differences and the costs of care, cost differences across plans. We then, in order to obtain premiums, added in CalPERS negotiated payments with these plans that yield total

premiums. Kaiser is more complicated, but we have a way to address that.

And as I noted, we implemented risk adjustment both in 2022 and 2023, where its complete. And then you get to do stage three, which is the fun part, putting all the moving pieces together and feeding alternative proposals through, and simulating what would happen, which generates your insights.

So next slide.

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DR. DAFNY: All right. So this tells you a little bit more about the simulations that we did. We considered the four plan expansion proposals that Dr. Moulds will be discussing. We also tried a number of hypothetical scenarios, which we won't take the time to go through in great detail, or really much detail today, but to generate some insights. And that's what I'll talk about.

There were a range of outcomes that we evaluated, in particular subscriber utility. Now, utility, as I mentioned, is that index of consumer satisfaction that reflects the benefit to a consumer of their choice net of the premium expense. So it's possible that you choose a higher cost plan, but generate a great deal of satisfaction from it, such that your net utility is

potentially higher than were you to select a lower cost plan. It depends on your preferences, and on the cost differences, and on your value of income, which is all built in there, right, with individuals from households in zip codes with lower median income, likelier to be more sensitive to premiums than others. So we have a good deal of variation in subscriber preferences.

We also looked at what happens under these scenarios to subscriber premiums, which depend also, of course, on what happens to State employer contributions, which in turn is a function of which plans are popular and what their premiums are. So they're really are a lot -- a lot of moving parts.

We can go to the next slide.

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DR. DAFNY: All right. So where do -- you know what are some big conclusions. You can feed things through the model and generate -- you know, you can do what-ifs. But based on our various simulations, we conclude, and you will see this in the plan expansion proposals, that variety can be quite valuable, particularly when the variety that you're offering isn't -- that you're adding isn't currently available.

So the example here is the Western Health Advantage proposal in Humboldt County, they don't have

access to a narrow HMO, either a narrow or a broad HMO, where they live. And that addition really does generate significant consumer benefit, and, you know, create some price pressure in that marketplace.

Another observation is really this interdependence across plans, and between plans, and the State -- or employer generally contributions is -- you know, I don't want to oversimplify and say it's tricky, but it's really tricky. For example, you introduce a plan and it attracts relatively healthy subscribers. And those subscribers have fairly low costs, so the premiums of that plan are relatively lower. That is true even after we implement risk adjustment. Risk adjustment just isn't perfect. Okay.

So in that case, then the premiums of the other plans rise, okay, which could diminish the utility of subscribers who continue to stay in those plans, unless those plans -- unless the State contribution rises enough to offset it, in which case the State is paying more. So you have to think about that. So that's the linkage.

On the other hand, if you were to introduce a plan and it attracted a lot of subscribers, then a rival plan might reduce its premiums in order to maintain its market share, and then premiums could go down for others, as well as for the State, right?

So it really depends on what -- you know, what you -- what you predict the reaction is going to be of large -- of large rivals in this marketplace to plans that you introduce. And so our model allows a variation in the strength of that response.

And as you are aware, because of the method of premium setting, change in one region can affect change -- can affect subscribers that are not there at all and we can see how much it affects them. So our simulations can show, you know, if you do something in Humboldt County, what happens to the rest of the state.

So it's a pretty neat tool. And I think the plan is now for Dr. Moulds to show you the expansion results.

CHIEF HEALTH DIRECTOR MOULDS: Great. Thank you, Dr. Dafny. If we can go to slide two of my presentation.

(Thereupon a slide presentation.)

CHIEF HEALTH DIRECTOR MOULDS: All right.

Are we on slide two?

Great. So I'm going to -- I'm going to start by walking you through the timeline, then I'll discuss the proposals that were approved contingent on the competition model and the new plan expansion for your action today. If we could go to slide three.

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CHIEF HEALTH DIRECTOR MOULDS: Here is a reminder

of the timeline for health plan proposals. You'll recall we moved up the timeline for approving proposals from the spring to the fall to allow for transparency in the rate development process, but also because it was challenging to analyze the full impact of the new proposals at the same time we were developing rates.

In August 2020, we asked our health plans to submit proposals for any changes to their existing plan products or for adding new plan products, and to provide CalPERS with applicable pricing, provider network and coverage areas details, as well as benefit design information. The carriers submitted proposals in September.

At the November PHBC, we brought the recommendations for plan proposals for your action. All we're approved, as I mentioned. Although, three were approved contingent on the results of competition model. Two are pending regulatory approval from the Department of Managed Health Care, and one, Blue Shield's proposal to expand Trio -- its Trio health plan into Monterey is contingent upon both ongoing negotiations with Community Hospital of Monterey Peninsula, which is the only hospital in that county, and DMHC approval.

In February, the CalPERS team took into consideration the results of the competition model. I'll

walk you through the outcomes of that analysis next. If we can turn to slide four.

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CHIEF HEALTH DIRECTOR MOULDS: The plan proposals that were contingent on the competition model -- we're sharing the slides you approved -- sharing the slides you approved in November, with the update of the results of the competition model.

For the Blue Shield proposal to reenter Access+ into eight of the nine Bay Area counties, the model suggests the proposal will significantly benefit Bay Area members by increasing plan choice, by creating competition among health plans in the region, and by putting downward price pressure on plans in all eight Bay Area counties.

As a reminder, Blue Shield exited the Bay Area starting in 2019 -- in the 2019 rate year. It proposed reentering the Bay Area contingent on the reintroduction of risk adjustment that was approved by the Board last November.

Next slide, please.

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CHIEF HEALTH DIRECTOR MOULDS: So Blue Shield proposed to expand its Trio health plan into four counties. Those were Monterey, Orange, Santa Cruz, and Stanislaus. The competition model shows that this

expansion will increase competition and could create modest downward price pressure in the four counties. As I mentioned, negotiations for the Monterey expansion are ongoing. And because there is a chance those negotiations may not be successful, we ask Dr. Dafny's team to analyze the expansion proposal with and without Monterey. The collective analysis is that either version of the expansion will create more choice, more competition, and favorable pricing.

Next slide, please.

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CHIEF HEALTH DIRECTOR MOULDS: UnitedHealthcare proposed its SignatureValue Harmoney basic HMO in five Southern California counties, Los Angeles, Orange, Riverside, San Bernardino, and San Diego.

The competition model shows that this new proposed health plan provides members a low cost alternative HMP option. Furthermore, this new proposed plan should increase competition and may result in lower prices in each of the five Southern California counties.

In each of these three plan proposals, the competition model showed increased competition and the potential for downward pressure on pricing. Again, no action is needed on these proposals, as you approved these in November, pending this update.

Next, is the new plan expansion proposal for your action.

Next slide, please.

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CHIEF HEALTH DIRECTOR MOULDS: Western Health Advantage is proposing a service area expansion into Humboldt County for their basic HMO plan. It will create the first low cost HMO available in Humboldt County. And the competition model tells us that this could cause significant downward price pressure in Humboldt County. Just say that we're very excited about this plan expansion. Not only does it check all of the boxes from the perspective of our competition model, but will -- it will also offer members a meaningful new choice in a rural California county.

By way of reminder, the Western Health Advantage proposal is contingent on regulatory approval from the Department of Managed Health Care.

The team recommends Board approval for this service area expansion.

Next slide, please.

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CHIEF HEALTH DIRECTOR MOULDS: This table summarizes the plan proposals presented today.

And the next slide.

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CHIEF HEALTH DIRECTOR MOULDS: And then for next steps, the CalPERS team recommends approval of the Western Health Advantage Basic HMO Humboldt County service area expansion proposal. We'll incorporate all of the approved plan proposals into the 2022 rate development process. You're going to get a first look at 2022 premiums in a May closed session. We will be bringing preliminary premiums to you in June open session. And final health plan premiums will come to the Board for approval in July. Approved premiums will take effect January 1st of next year.

And that concludes my presentation. I'm happy to answer any questions.

CHAIRPERSON FECKNER: Thank you. I know we have a couple of callers on the line, but I have Ms. Greene-Ross first.

ACTING COMMITTEE MEMBER GREENE-ROSS: Yes, Mr. Moulds, I just had a question about the consultants unable to -- maybe it was a timing issue that we didn't -- and I wasn't -- they said it didn't have a huge impact, but not having access to our local employer participant's data. I thought we had all that in our database.

CHIEF HEALTH DIRECTOR MOULDS: We don't. And Dr. Dafny, if you want to elaborate.

DR. DAFNY: Sure. Absolutely. We have a lot of that information in the database. We're able to incorporate those lives in terms of predicting costs and observing choice. What we don't have access to is the employer contributions on their behalf, which means we're guesstimating what the out-of-pocket subscriber premiums are. So we make use of them where we can, but we don't where we don't have the data.

CHIEF HEALTH DIRECTOR MOULDS: Yeah. So it's -- the data we have gives a lot of -- there are a lot of data points within that data, but --

ACTING COMMITTEE MEMBER GREENE-ROSS: Yeah.

CHIEF HEALTH DIRECTOR MOULDS: -- (inaudible), the data points. You know, we've talked about future iterations and the possibility of doing a call for that information. But, you know, we -- it is challenging, given the sheer number of public agencies.

DR. DAFNY: Right. For right now, we're assuming that their choices are similar to the choices that the conditional, all the observed characteristics that State employees would make, and they're supporting the data that they look fairly similar again conditional on having certain age and household income -- median household income and the zip code, et cetera. But that would be a nice thing to build in.

ACTING COMMITTEE MEMBER GREENE-ROSS: Yeah, I misunderstood and thought that also would be public information.

DR. DAFNY: We weren't able to get it.

CHIEF HEALTH DIRECTOR MOULDS: Yeah.

DR. DAFNY: It's actually surprisingly complicated just to even figure out, for which part -- which member is in the -- there was a lot of back and forth, in your own data what their -- you know, is it 80 -- 85, 80. Anyway, there's a lot of moving parts, I suppose.

ACTING COMMITTEE MEMBER GREENE-ROSS: And if it's -- if we have enough other data and it's not -- and we can -- and obviously if you can model and ballpark with what you have, just --

DR. DAFNY: I don't --

ACTING COMMITTEE MEMBER GREENE-ROSS: -- I jus wonder -- I just wondered how much of an impact that would have been on changing the results in any way, shape, or form, but it sounds like it wouldn't have made a difference.

DR. DAFNY: You know, it makes -- we make some assumptions about that population, because we need their total enrollment, right, to figure out --

ACTING COMMITTEE MEMBER GREENE-ROSS: Yeah.

DR. DAFNY: -- costs, et cetera. But my comfort level is pretty good with the volume of data we have for all the other pieces. So I feel -- I mean, my advice is that it's probably -- the juice isn't worth the squeeze.

(Laughter.)

ACTING COMMITTEE MEMBER GREENE-ROSS: Great Expression. Thank you very much. Appreciate it.

(Laughter.)

CHAIRPERSON FECKNER: Thank you.

Mr. Rubalcava.

VICE CHAIRPERSON RUBALCAVA: Thank you, Mr. Feckner. Very good presentation. And, Dr. Dafny, I'm very impressed with the model. A couple times you mentioned -- described utility or economic utility. And I guess that's a layman comment. But the value to members. And I'm always interested in how do you -- you called it an index on consumer satisfaction, but it's always hard to understand how people measure value. Because I think a lot of it is influenced by marketing from -- not so much from the provider -- I'm sorry, from -- either depending from the provider or the carrier. And sometimes they're confused. They want this plan, not understanding that it's plan design that they're really talking about.

And so my question is because one thing that's very unique to the action we took in November is we're

adding -- expanding or adding new narrow networks. And narrow networks, depends how the -- I'm interested how the members perceive it, because on one hand it does attract -- it does bring you a lower priced HMO, and it may be the same physician you had, but for other people there will be disruption.

But yet, they're gaining -- some people may not want to move, because their physician -- they'll have to change physicians, so they see that disruption as a bad thing. But some people will see the price a better thing. And yet, the insurance carrier, they'll -- they will argue that the narrow network is a better net value, because they have more control over the provider, and somehow it's a better contract, and there's better outcomes.

So members don't tend to look at outcomes, I don't think. They look at other things.

(Laughter.)

VICE CHAIRPERSON RUBALCAVA: So I was wondering how -- what your studies on -- how did your model qualifies consumer satisfaction, and especially on this -- if you could speak to the narrow network dilemma, because some people see that as a good thing, some see it as disruption.

DR. DAFNY: Right.

VICE CHAIRPERSON RUBALCAVA: And it does impact

if -- you know, flight does impact the full network, for example. I'm familiar with more regions where it's the same per -- insurance carrier providing a full network and a narrow network, and you see the flight, and you -- it depends on the employer whether they want to keep the differential the same, or let it flow, and kill it. And sometimes I think it's introduced just to compete with a larger HMO, that they'll argue is still bigger -- their narrow network is still bigger than Kaiser, for example. They'll say that.

So I'm just curious how your -- Doctor, how your model compensates for that. And it's just intriguing to me to do a model this size.

DR. DAFNY: Yeah. No, it's a -- it's a fascinating discussion. And I will, you know, right off the bat tell you a model can't fix everything. But let me just tell you what it assumes. So it assumes that your observed choices, that -- the choices that people make are -- are Mr. Rubalcava right.

Okay. So if it is marketing that is why you -- or if it is that you like the lobby at Kaiser, if that is why you choose it, then it is your choice. And if it's the case that we observe a set of individuals facing a certain choice set and there is, you know, a Mercedes plan and a Mercedes price, and there is a narrow plan and a

narrow price, and they pick this one, then we say that they are more satisfied than they would be from this one.

Now, as you point out, that might not involve true quality. But just as with other consumer products, we don't -- I don't know if this is appropriate to say, but we don't judge. We say you want -- you want that car, you can pay for that car, you have that car.

Now, I think a way we can assist people in making choices that they aren't, after the fact, unhappy with is giving them information about the quality, right? I know, because I can look up all kinds of car ratings, what I'm buying, right? Okay.

And I'm never buying a Mercedes. But it is much hard to do with health care and I might not currently be experiencing a need for knee surgery, so I might not know about the limitations on how many knee surgeons I can see. And so I might not value that. So that's the role of the employer in trying to provide that education. Although, at some level, people make choices. They don't save for retirement, but they maybe don't pick broad network plans, even if -- if later they -- perhaps, we've -- you know, if -- if we were making the decision, we would think they should.

So the concept of utility is based on what you choose and what people who look like you with your risk

scores, and location, et cetera, choose what you chose last year, because a lot of -- you know, you have a fairly low turnover -- low turnover population.

You asked the question about narrow networks, which I think is a really interesting discussion. What I would say is the following, which is, because I've studied narrow networks, in particular on health insurance exchanges, you know, for the individual market, it is, of course, the case that lower income individuals are more price sensitive and more likely to pick cheaper plans. So it's got distributional impacts.

On the other hand -- and it may -- it -- right, and they may not be aware that they don't have as broad a choice of providers, or if they are aware, they aren't, you know, able to feel -- be in a position to make that trade-off. What I will say is that broad providers -- the other providers who are left out have a greater incentive to contain their costs and stop say merging in order to raise prices, if there is a threat in the market.

So it's not just about, you know, limiting choice. It's also about injecting consumer competition. Just as Mercedes looks around and says, hey, you know, Lexus is out there offering a pretty good car at a lower price, that's the same idea, which is, wait, that's a pretty good narrow network. It has access to such and

such academic medical center for these kinds of things. Maybe I really can't raise my price. So rejecting narrow networks, because it does have that tradeoff also has market implications.

VICE CHAIRPERSON RUBALCAVA: No, I find that fascinating.

(Laughter.)

VICE CHAIRPERSON RUBALCAVA: But I would just -- I don't want to prolong the discussion, but I would just speak to one item you said about how narrow networks tend to -- lower income people are, of course, sensitive to price. But also, access is an issue. We dealt with this -- I'm from Southern California. There are -- our members tend to live in a corridor, like downtown down to the Long Beach area. And the -- the lower income people. And -- income. And they don't have access to narrow networks, because their plans tend to be older. And so narrow networks tend to go with the higher tech, more developed, more innovative medical groups and hospitals. So I think it depends, you know.

DR. DAFNY: Yes.

VICE CHAIRPERSON RUBALCAVA: But nonetheless, I do want to thank you and Mr. Moulds for bringing this competitive study, because that helps reaffirm our hunch or decision that these expansions and these new plans are

worth it.

Thank you very, very much. Thank you, everybody.

DR. DAFNY: Pleasure.

CHAIRPERSON FECKNER: Thank you.

Mr. Miller.

COMMITTEE MEMBER MILLER: Yeah. Thank you, Dr. Dafny and Mr. Moulds. I really -- I think most of what I wanted to ask was asked by Director Rubalcava. This whole issue of, you know, the stickiness of people, and how their perceptions of, you know, what you described as subscriber utility in terms of the way we may be impacted, you know as -- in terms of costs and in terms of costs, particularly for our employers, when people seem to be so very much influenced by the brand management, and the advertising by some particular providers, particularly some of these providers that are very high cost, but that despite -- if you look at, you know, real quality measures, kind of empirical measures, CMS quality measures or something, they're not proportionate in terms of they really -- it's like the advertising, the impression people have and make their choices is way out of proportion to any real kind of tangible benefit in terms of health care delivery, in terms of quality by objective measures and cost.

And it's hard to see how we can kind of get a

handle on that, when, even if we published a full panel of, you know, measures, of clinical excellence, frankly, I think many of our constituents are much more influenced by the ads they see on TV, and the shiny facilities and the -- you know, the -- this reputation and brand that has been built.

And so, yeah, it's almost more a comment than a questions. But if you have any thoughts on how we could address that, because it really impacts us, our constituents, and our employers in terms of their choices, and what it costs us.

DR. DAFNY: I have a thought, but it's a complicated one, but it's what CalPERS is famous for, among academics - I'm sure you're famous for many things - but is reference pricing, where you say this is a price where we can get something at good quality, and then the consumer bears the difference in the cost. And then they can choose do we, you know, want the shiny facilities, given what it costs.

That said, you have a certain formula for your contributions, a very complicated one, Ms. Greene-Ross. So I understand that a change like that is pretty huge, but very difficult without having the consumer bear the difference in cost for these things to get movement in their choices.

COMMITTEE MEMBER MILLER: Thank you.

CHAIRPERSON FECKNER: Thank you.

Ms. Taylor.

COMMITTEE MEMBER TAYLOR: Yes. Thank you. Thank you for this presentation. I'm always -- my members I have a lot that are in Northern California in the rural areas, and in the very south of the state in the rural areas that work in our prisons and places like that. So I'm grad to see that we are expanding outside of maybe some of the more populated areas, such as Stanislaus and Humboldt.

I thought, and I cannot remember for sure which plan it was, was looking to expand -- I think we got this report in November, Mr. Moulds, to Lassen and Shasta?

CHIEF HEALTH DIRECTOR MOULDS: Lassen and I believe it's Alpine. That's Blue Shield Access+.

COMMITTEE MEMBER TAYLOR: I didn't see it there.

CHIEF HEALTH DIRECTOR MOULDS: And we -- so we approved those. Those were not -- those were not planned expansions that we needed to run through the competition analysis, because there were not HMOs in those areas. So those were approved in November.

COMMITTEE MEMBER TAYLOR: Okay. So those were approved in November?

CHIEF HEALTH DIRECTOR MOULDS: Correct. There

were a bunch --

COMMITTEE MEMBER TAYLOR: And we've got alpine and Lassen?

CHIEF HEALTH DIRECTOR MOULDS: Let me double check that it's Alpine and not Shasta.

Karen, do you remember, is it Alpine or Shasta? I should know that.

(Laughter.)

HEALTH POLICY RESEARCH ACTING DIVISION CHIEF PÁLES: Yeah, I'm also looking. I can't --

COMMITTEE MEMBER TAYLOR: It's okay. If you can get back to me, that's fine. You don't have to find it right this very minute.

And then I just had --

CHIEF HEALTH DIRECTOR MOULDS: (Inaudible) not distinguishing Alpine and Shasta. It's a --

COMMITTEE MEMBER TAYLOR: It will make people mad, I know.

CHIEF HEALTH DIRECTOR MOULDS: The people who live in Alpine and Shasta, yes.

COMMITTEE MEMBER TAYLOR: They're both beautiful though, so...

CHIEF HEALTH DIRECTOR MOULDS: They are, which is part of the challenge.

COMMITTEE MEMBER TAYLOR: Have we looked at -- so

I have a lot of members that work down south all the way at the border. Have we looked into -- any of our plans ever looked into going down that far into Southern California?

CHIEF HEALTH DIRECTOR MOULDS: So we have pretty good penetration in the southern parts of the state. There tends to be more competition in those areas.

COMMITTEE MEMBER TAYLOR: This is like Donovan State Prison. So we're looking at --

CHIEF HEALTH DIRECTOR MOULDS: So Imperial or --

COMMITTEE MEMBER TAYLOR: Yeah. Yeah, it's further east.

CHIEF HEALTH DIRECTOR MOULDS: Yeah. So in Imperial -- so in San Diego, we have several plans. I'll get back to you with the list of plans, but I think Imperial has pretty good penetration as well.

COMMITTEE MEMBER TAYLOR: Okay. I appreciate it.

CHIEF HEALTH DIRECTOR MOULDS: Yeah. I know Salud y Más, for example, is in Imperial. So there's some -- some interesting plans down there.

COMMITTEE MEMBER TAYLOR: I know Salud y Más is down there. I thought it was just LA though. Am I wrong? That's Imperial?

CHIEF HEALTH DIRECTOR MOULDS: I think it's in Imperial as well.

COMMITTEE MEMBER TAYLOR: Okay. And then I -- the Lassen and Shasta/Alpine, there was no approval that needed to happen through DMHC or anything?

CHIEF HEALTH DIRECTOR MOULDS: No.

COMMITTEE MEMBER TAYLOR: Okay. Cool.

HEALTH POLICY RESEARCH ACTING DIVISION CHIEF PÁLES: Don, the Blue Shield Access+ expansion was Lassen and Shasta.

CHIEF HEATH DIRECTOR MOULDS: And Shasta. You got it right and I got t wrong.

COMMITTEE MEMBER TAYLOR: Got it. Thank you.

HEALTH POLICY RESEARCH ACTING DIVISION CHIEF PÁLES: Lassen and Shasta.

COMMITTEE MEMBER TAYLOR: Thank you very much.

CHAIRPERSON FECKNER: Pretty good. Thank you.

Seeing no other requests, we do have a couple of requests from the audience. Mr. Fox.

STAKEHOLDER RELATIONS CHIEF FOX: Yes, Mr. Chair. We have two callers on Item 7A. The first caller is Lisa Bocast from SEIU.

CHAIRPERSON FECKNER: Thank you.

MS. BOCAST: Hello. My name -- can you hear me?

CHAIRPERSON FECKNER: Yes.

MS. BOCAST: Okay. Thank you for this opportunity to speak. As I was introduced, I'm Lisa

Bocast. I'm a State employee and a member of SEIU Local 1000. I wanted to share my story today to provide concrete examples of the type of problems that the State workers are facing. And I hope that you continue to address these problems. And I am from Shasta County, so I was excited to hear some of the new changes.

In 2017, my son needed surgery. And I made sure I got all my pre-authorizations with both the hospital and the surgeon well in advance. Surgery day came, everything went well, and he healed with no complications. However, about three weeks later, I got a bill for $23,000. The entire surgery had been denied. And when I called the hospital, I was referred to the insurance company. And I called and I questioned why the surgery had been denied, as I had my authorizations and -- I was informed that the anesthesiologist was not in network, so the entire surgery was denied.

And then I asked how I would have known this, because I didn't even know which anesthesiologist would be assigned to my son's surgery until about five minutes before the surgery.

I was told that it was my responsibility to check to see if the doctors treating my family are in network. And I asked how I was to know this. And I was told there's an app for this. So I have five children, four

are boys. Boys fall down. They break bones. They split things open. So what they were telling me is that if my nine year old falls off his bike and needs to go to the hospital, I'm supposed to ask, excuse me, Doctor, what's your name, check the app, oh, I'm sorry, you're not in my network. You can't treat my child. Then go to the next doctor and again ask his name, check the app, and verify whether or not he was in my network.

This is ridiculous as a parent or a patient. Our members should not have to jump through these kinds of hoops to get treatment. This is unacceptable.

As it turns out, Redding has two hospitals. Both of them are in network. However, few, if any of the doctors employed by these hospital are in network.

Another example of rural health care issues happened in July of 2020. I was scheduled for an endoscopy and a colonoscopy by my doctor in Chico, which is 90 miles away from where I live. And it was scheduled at Saint Elizabeth's hospital in Red Bluff, which my doctor has rights at, which is about 30 miles away from where I live.

I went in for my pre-op appointment on Friday and was cleared for this appointment for the following Wednesday. On Monday, I got a call from doctor's office telling me that the hospital was refusing to treat me,

because I did not live in Tehama County. I live in Shasta County.

Now, I'm scrambling -- now I was scrambling to reschedule this procedure as it was a prerequisite for Anthem Blue Cross for an upcoming scheduled surgery.

These are just a few examples of the struggle of health care in rural areas.

Thank you for your time and for listening.

Thank you.

CHAIRPERSON FECKNER: Thank you for your comments. And Mr. Moulds, could you have somebody reach out to this member and find out what's going on -- these -- we're dealing with providers and it doesn't sound like they're actually providing if our members have to try and look up this information themselves.

CHIEF HEALTH DIRECTOR MOULDS: Yeah.

CHAIRPERSON FECKNER: That seems to be out of the scope of what our patients and members should be dealing with.

CHIEF HEALTH DIRECTOR MOULDS: Yeah, absolutely. I was just going to ask Mr. Fox to share my information and we'll be in touch with her. That's completely unacceptable.

CHAIRPERSON FECKNER: Excellent. Thank you.

Mr. Fox.

STAKEHOLDER RELATIONS CHIEF FOX: Yes. Mr. Moulds, we will do that.

Next caller also from SEIU Laura Slavec.

MS. SLAVEC: Good morning. Hello.

CHAIRPERSON FECKNER: Good morning.

MS. SLAVEC: Good morning. Thank you for allowing me to speak this morning. So my name is Laura Slavec. I am a registered dental assistant at Pelican Bay State Prison. I have been providing this service for the State for almost nine years. I live in Del Norte County, where we only have one hospital, Sutter Coast. Last February, my 14-year old son came -- who by the way has an extremely high pain tolerance, was throwing up and was complaining about tremendous pain in his groin area.

I called his physician and they were able to get him in right away. Once he got into a room and the physician was able to examine him, the physician explained that he might have testicular torsion. The PA said that this is a time-sensitive matter, that he could possibly lose one or both of his testicles if surgery was performed. The PA then called over to Sutter coast, to see if there was a surgeon that could perform the surgery, if surgery was needed to be done. The answer was no. So instead of wasting time going to Sutter Coast and then possibly having him life flighted out or whatever the

thought was most appropriate to get him the surgery, I rushed my son to Grants Pass, Oregon which us almost two hours away on a very curvy road.

The PA had called over to the Grants Pass Hospital and had set up and let them know that I -- that we'd be coming and what was going on. So when we arrived, they were ready to take us back and do all necessary tests to determine what was going on. Lucky for my son, he did not have to have surgery.

How can the only hospital in a two-hour radius not be a equipped to handle the community's needs. The fact is they could not accommodate something that was extremely time sensitive. If my son did have testicular torsion, that two hours it took to go to the hospital would have cost him and changed his life forever. This is just the most recent encounter. I have plenty other experience that are far from satisfactory when it comes to Sutter Coast. And all the locals here in Crescent City and Del Norte County like to call the hospital Slaughter Coast.

Change needs to happen. Thank you so much for your time.

CHAIRPERSON FECKNER: Thank you for your call and your comments.

Mr. Moulds, anything to add?

CHIEF HEALTH DIRECTOR MOULDS: No, except just to share my condolences for what sounds like an absolutely horrid experience. And I'd also like to be in touch to get some more details, if that's -- if that's possible. We'll have Mr. Fox connect us, if the caller is willing to discuss them in more details.

CHAIRPERSON FECKNER: Excellent. Thank you.

I have Ms. Taylor.

COMMITTEE MEMBER TAYLOR: Thank you. I just wanted to make sure, based on Ms. Bocast's comments, I'm just kind of a little weirded out over the fact that you have a hospital that's in network and physicians aren't in network. So I want -- and I know Mr. Moulds you said you're going to talk to her.

CHIEF HEALTH DIRECTOR MOULDS: Yeah.

COMMITTEE MEMBER TAYLOR: Is that a normal problem within --

CHIEF HEALTH DIRECTOR MOULDS: It can certainly be a challenge. You know, the -- one of the -- we've -- Ms. Green and I have spoken quite a bit about some of the challenges with surprise bills, particularly in regional -- in rural California rather. And, you know, our HMO enrollees are protected by very strong State legislation. We are very, very pleased to see the legislation that passed Congress at the end of last year.

It will go into effect, not until January 1st 2022. So our PPO members are still vulnerable to this. You know, we are certainly willing and eager to get involved to make sure that we've done everything we can do to protect them. In 2022, there will be significant protections for our PPO members that aren't exactly the same as the protections for our State members, but are pretty close, in some cases, a little bit stronger, in some cases, a little bit weaker.

You know, there's still work to be done on the federal level on this issue. We need to bring in ground ambulances under the surprise billing protections. But they're good. They will help. But this is a really nefarious horrible problem and I hate hearing stories like this. It is incredibly frustrating.

COMMITTEE MEMBER TAYLOR: Okay. So let me -- I mean, that's great. So what the means is these folks that are in our rural areas have to have the PPO, because that's what -- all they can have.

But is this law, the federal law, going to force these physicians to actually enter the networks, because they're just not going to get paid, is that how -- hopefully what happens, because of the surprise billing life?

CHIEF HEALTH DIRECTOR MOULDS: Yeah. So, you

know, the network should include -- should include, you know, reasonable services. In some of these rural areas, the, you know, coverage can be more challenging than in other areas. Del Norte county is a -- is a, you know, extremely low population county, which is where you often see some of these challenges.

You know, the federal -- the federal law will go a long way towards protecting from -- certainly from the surprise billing. The network adequacy -- the network adequacy laws that affect the State health plans, our HMOs are not in effect for PPOs, for our self-insured side. But part of the reason that I want to be in touch with her is that -- is that this sounds like a shortcoming in the network potentially. And I want to make sure that if that's the case, it's remedied.

COMMITTEE MEMBER TAYLOR: I appreciate that. And, yeah, I just want to let Lisa and Laura know that definitely we want to --

CHIEF HEALTH DIRECTOR MOULDS: Please do.

COMMITTEE MEMBER TAYLOR: Yeah. So I appreciate, Mr. Moulds. Thank you.

CHAIRPERSON FECKNER: All right. Thank you.

Seeing no other requests to speak.

This is an action item. What's the pleasure of the Committee?

ACTING COMMITTEE MEMBER GREENE-ROSS: Move to approve.

COMMITTEE MEMBER MILLER: Second.

CHAIRPERSON FECKNER: Who was the motion?

ACTING COMMITTEE MEMBER GREENE-ROSS: Oh, Karen.

CHAIRPERSON FECKNER: Okay. Motion by Ms. Greene-Ross, seconded by Mr. Miller.

Any discussion on the motion?

Seeing none.

Ms. Hopper, please.

COMMITTEE SECRETARY HOPPER: Margaret Brown?

COMMITTEE MEMBER BROWN: Aye.

COMMITTEE SECRETARY HOPPER: Henry Jones?

COMMITTEE MEMBER JONES: Aye.

COMMITTEE SECRETARY HOPPER: David Miller?

COMMITTEE MEMBER MILLER: Aye.

COMMITTEE SECRETARY HOPPER: Eraina Ortega?

COMMITTEE MEMBER ORTEGA: Aye.

COMMITTEE SECRETARY HOPPER: Ramon Rubalcava?

VICE CHAIRPERSON RUBALCAVA: Aye.

COMMITTEE SECRETARY HOPPER: Theresa Taylor?

COMMITTEE MEMBER TAYLOR: Aye.

COMMITTEE SECRETARY HOPPER: Shawnda Westly?

COMMITTEE MEMBER WESTLY: Aye.

COMMITTEE SECRETARY HOPPER: Karen Greene-Ross

for Betty Yee?

ACTING COMMITTEE MEMBER GREENE-ROSS: Aye.

COMMITTEE SECRETARY HOPPER: Mr. Chair, I have a motion being made by Karen Greene-Ross for Betty Yee, seconded by David Miller on Item 7A, competition study and 2022 new plans, area expansion and benefit changes.

CHAIRPERSON FECKNER: Excellent. Thank you very much.

That moves us to Agenda Item 8a, information item, update on retiree cost of living adjustment.

Mr. Suine

DEPUTY EXECUTIVE OFFICER SUINE: Good morning again, Mr. Chair and members of the Committee. Anthony Suine, CalPERS team member.

And I would like to take this opportunity to introduce you to Kimberly Pulido, who succeeded me in the role of Division Chief over the Retirement Benefit Services Division. And she is going to be presenting the cost of living adjustment item to you. So I will turn it over to Kimberly.

RETIREMENT BENEFIT SERVICES DIVISION CHIEF PULIDO: Good morning, Mr. Chair and members of the Committee. Kimberly Pulido, CalPERS team member.

I'd like to start by congratulating Mr. Feckner and Mr. Rubalcava on your reelections to your Chair and

Vice Chair positions.

Agenda Item 8a is our annual information item update on the retiree cost of living adjustments, more routinely referred to as COLA. 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 CPIU, which is the consumer price index for all urban consumers.

A retiree becomes eligible for COLA in the second calendar year of retirement. Therefore, members who retired on -- or in 2019 or prior are eligible to receive a COLA benefit this year. For the year ending 2020, the rate of inflation, as measured by the CPIU was 1.23 percent. Approximately 95 percent of our retirees are contracted for a two percent COLA. Those eligible will receive at least a 1.23 percent adjustment on this May 1st retirement check.

Because of the lower inflation in some previous years, members who retired in certain years will receive the full two percent. We also have less than five percent of retirees who are part of employers who have contracted for a three, four, or five percent COLA. Those in this group will receive at least 1.23 percent as well up to their contracted amount.

This agenda item provides a helpful chart for

retirees to determine what they should expect for a COLA increase based on their retirement date. This information has also been shared with our stakeholders and is available on our newsletter and on our website for our members.

That concludes my update and I'm happy to take any questions.

CHAIRPERSON FECKNER: Thank you very much, Ms. Pulido. I don't see any questions, so it must have been a great presentation.

Thank you.

RETIREMENT BENEFIT SERVICES DIVISION CHIEF PULIDO: Thank you very much.

CHAIRPERSON FECKNER: Anything else on this, Mr. Suine?

DEPUTY EXECUTIVE OFFICER SUINE: No, that's it, Mr. Chair. Thank you.

CHAIRPERSON FECKNER: Very good. Thank you.

Item 8a -- 8b, summary of committee direction. Mr. Moulds.

CHIEF HEALTH DIRECTOR MOULDS: So I have two. The first is to do a behavioral health briefing at a future PHBC meeting. And then the second is to keep this Committee affirmed -- I'm sorry, informed of any changes that we're seeing in our future liabilities in the

Long-Term Care Program.

CHAIRPERSON FECKNER: Thank you. I think you've got it. And when we talk about the behavioral health, when you bring that back, I, for one, am not interested in having the providers come back and talk to us again, like talking heads. I'd rather see you and Dr. Logan do the heavy lift and then bring us back the information on each plan.

CHIEF HEALTH DIRECTOR MOULDS: Happy to do that.

CHAIRPERSON FECKNER: Very good. Thank you.

The next item is the public comment. Is there anybody for public comment, Mr. Fox?

STAKEHOLDER RELATIONS CHIEF FOX: No, Mr. Chair. That concludes public comment.

CHAIRPERSON FECKNER: Very good. Thank you very much.

Next up will be the Board Governance Committee. Mr. Jones, what time would you like to start?

COMMITTEE MEMBER JONES: 11:30.

CHAIRPERSON FECKNER: All right, 11:30 for Board Governance. Everyone take care. Thank you for joining us for the PHBC meeting and we'll see you soon.

This meeting is adjourned.

(Thereupon California Public Employees' Retirement System, Pension and Health Benefits

Committee open session meeting adjourned at 11:18 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 20th day of March, 2020.

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