

VIDEOCONFERENCE MEETING  
STATE OF CALIFORNIA  
PUBLIC EMPLOYEES' RETIREMENT SYSTEM  
BOARD OF ADMINISTRATION  
PENSION & HEALTH BENEFITS COMMITTEE  
OPEN SESSION

ZOOM PLATFORM

TUESDAY, JUNE 15, 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, represented by Nicole Griffith

Theresa Taylor

Shawnda Westly

Betty Yee, represented by Ms. Karen Greene-Ross

BOARD MEMBERS:

Fiona Ma, represented by Mr. Frank Ruffino

Lisa Middleton

Stacie Olivares

STAFF:

Marcie Frost, Chief Executive Officer

Matt Jacobs, General Counsel

Donald Moulds, PhD, Chief Health Director

Anthony Suine, Deputy Executive Officer

Marta Green, Chief, Health Plan Research & Administration  
Division

Pam Hopper, Committee Secretary

APPEARANCES CONTINUED

ALSO PRESENT:

Alvin Barrett

Tim Behrens, California State Retirees

Maria Blaine, Service Employees International Union

Lisa Bocast, Service Employees International Union

Polly Coghlin, Service Employees International Union

Susan Cohen

Debbie Gibson, Service Employees International Union

Lawrence Grossman

J.J. Jelincic, Retired Public Employees Association

Joanne Hollender, Retired Public Employees Association

Jared Ramey, Service Employees International Union

Alexandra Tkacheff, Service Employees International Union

Larry Woodson, California State Retirees

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PROCEEDINGS

1  
2 CHAIRPERSON FECKNER: We're going to call the  
3 Pension and Health Committee meeting to order. First  
4 order of business will be to call the roll.

5 Ms. Hopper, please.

6 COMMITTEE SECRETARY HOPPER: Rob Feckner?

7 CHAIRPERSON FECKNER: Good morning.

8 COMMITTEE SECRETARY HOPPER: Margaret Brown?

9 COMMITTEE MEMBER BROWN: Good morning.

10 COMMITTEE SECRETARY HOPPER: Henry Jones?

11 COMMITTEE MEMBER JONES: Here.

12 COMMITTEE SECRETARY HOPPER: David Miller?

13 COMMITTEE MEMBER MILLER: Here.

14 COMMITTEE SECRETARY HOPPER: Nicole Griffith for  
15 Eraina Ortega?

16 ACTING COMMITTEE MEMBER GRIFFITH: Here.

17 COMMITTEE SECRETARY HOPPER: Ramon Rubalcava?

18 VICE CHAIRPERSON RUBALCAVA: Present.

19 COMMITTEE SECRETARY HOPPER: Theresa Taylor?

20 COMMITTEE MEMBER TAYLOR: Here.

21 COMMITTEE SECRETARY HOPPER: Shawnda Westly?

22 COMMITTEE MEMBER WESTLY: Here.

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

25 ACTING COMMITTEE MEMBER GREENE-ROSS: Here.

1           COMMITTEE SECRETARY HOPPER: Mr. Chair, I have  
2 all in attendance.

3           CHAIRPERSON FECKNER: Thank you very much. We're  
4 now going to recess into closed session for items 1  
5 through 3 from the closed session agenda. So at this  
6 time, the Board members will please exit this open session  
7 and connect to the closed session meeting.

8           For those of the public that are listening, we  
9 will be back with open session after we finish our closed,  
10 after the Board Governance Committee meeting, and probably  
11 after lunch. So we will be back in open session, but it  
12 will be some time now. We'll see you all in closed  
13 session, Board members.

14           (Off record: 9:01 a.m.)

15           (Thereupon the meeting recessed  
16 into closed session.)

17           (Thereupon the meeting reconvened  
18 open session.

19           (On record: 12:47 p.m.)

20           CHAIRPERSON JONES: Welcome back, everyone. We  
21 are continuing the open session. We've adjourned the  
22 closed session. We're on Item 2 of the open session,  
23 which would be to approve the minutes -- timed agenda of  
24 June 15th. What's the pleasure of the Committee?

25           BOARD MEMBER MILLER: So moved.

1 CHAIRPERSON FECKNER: Is there a second?

2 VICE PRESIDENT TAYLOR: Second.

3 CHAIRPERSON JONES: Moved by Mr. Miller, seconded  
4 by Ms. Taylor.

5 Any discussion on the motion?

6 Seeing none.

7 Ms. Hopper, please call the roll.

8 COMMITTEE SECRETARY HOPPER: Margaret Brown?

9 COMMITTEE MEMBER BROWN: Aye.

10 COMMITTEE SECRETARY HOPPER: Henry Jones?

11 COMMITTEE MEMBER JONES: Aye.

12 COMMITTEE SECRETARY HOPPER: David Miller?

13 COMMITTEE MEMBER MILLER: Aye.

14 COMMITTEE SECRETARY HOPPER: Nicole Griffith for  
15 Eraina Ortega?

16 ACTING COMMITTEE MEMBER GRIFFITH: Aye.

17 COMMITTEE SECRETARY HOPPER: Ramon Rubalcava?

18 Don't see him yet.

19 COMMITTEE SECRETARY HOPPER: Theresa Taylor?

20 COMMITTEE MEMBER TAYLOR: Aye.

21 COMMITTEE SECRETARY HOPPER: Shawnda Westly?

22 COMMITTEE MEMBER WESTLY: Aye.

23 COMMITTEE SECRETARY HOPPER: Karen Green-Ross for  
24 Betty Yee?

25 ACTING COMMITTEE MEMBER GREENE-ROSS: Aye.

1 COMMITTEE SECRETARY HOPPER: Mr. Chair, I have a  
2 motion being made by David Miller, seconded by Theresa  
3 Taylor, all ayes. As of yet, I do not see Ramon Rubalcava  
4 in. And that is on Agenda Item 2, Pension and Health  
5 timed agenda.

6 CHAIRPERSON FECKNER: Very good. Thank you.  
7 Brings us to Agenda Item 3, the executive report. Mr.  
8 Moulds and Mr. Suine who's going first today.

9 DEPUTY EXECUTIVE OFFICER SUINE: I'll be going  
10 first, Mr. President -- Mr. Chair.

11 CHAIRPERSON FECKNER: Very good.

12 DEPUTY EXECUTIVE OFFICER SUINE: Are you ready  
13 for me?

14 CHAIRPERSON FECKNER: We are. Go right ahead,  
15 sir.

16 DEPUTY EXECUTIVE OFFICER SUINE: All right. Good  
17 morning -- good afternoon, Mr. Chair and members of the  
18 Committee. Anthony Suine, CalPERS team member. And it's  
19 great to see you all again. While this has been a  
20 repetitive theme of mine at the top of my updates, I'm  
21 happy to continue to report that our benefit payments are  
22 still being processed in a timely manner and our customer  
23 service and satisfaction levels remain very high across  
24 all our processes within the Customer Services and Support  
25 Branch.



1           We continue to monitor retirement trends to help  
2 us manage our workload and we remain fairly steady in the  
3 first quarter of 2021 compared to this same time last  
4 year, and that's across all our employer sectors, State,  
5 public agencies, and schools.

6           Focusing on the education of our members, we  
7 continue to explore our options for best serving them in a  
8 hybrid environment going forward. In the meantime, we  
9 continue our virtual counseling appointments and have  
10 completed more than 15,000 virtual appointments since we  
11 last met in March. Those are mainly conducted by phone,  
12 but we're also able to accommodate video appoint -- video  
13 appointments, if the member chooses.

14           We are currently planning outreach to our members  
15 to help assess our future delivery model. We're asking  
16 them their technical capabilities, how far they are  
17 willing to travel for services, and ultimately what type  
18 of delivery they prefer.

19           While we have had great success in the virtual  
20 environment, and we know it will continue in some fashion,  
21 member preferences will ultimately drive our delivery  
22 model into the future.

23           Shortly after I gave my last update in March, we  
24 delivered our third virtual CalPERS Benefit Education  
25 Event. At that event, we unveiled new enhancements,

1 including an interactive information center that allowed  
2 members to connect directly with the experts for live  
3 questions and a resource center that provided a variety of  
4 topic-specific informational materials that they could  
5 download and review at their convenience.

6 We offered 20 classes over two days that  
7 attracted nearly 5,000 attendees, the majority of which  
8 attended both days. And satisfaction ratings for the  
9 classes and the overall events were in the high 90th  
10 percentile, and our website data shows an encouraging  
11 trend that the members stayed engaged with the resources  
12 provided online and took the time to explore them more on  
13 their own after the event.

14 Our next virtual event is slated for December and  
15 we're making plans to conduct a blend of in-person and  
16 virtual events next year. I know our members appreciate  
17 seeing many of our Board members at those in-person  
18 events, so we'll look forward to seeing you there in 2022.

19 As I shared back in March, we have some great new  
20 online functionality related to service credit purchases.  
21 We've enabled members to calculate the cost of a service  
22 credit purchase, and elect it from their member  
23 self-service accounts. The easy-to-use on-line method  
24 guides members through a questionnaire. Based on their  
25 CalPERS account information and appointment details, it

1 displays which service credit types they may be able to  
2 purchase.

3           In the first four months of implementation, 36  
4 percent of costing requests received were electronically  
5 submitted by members, including one by myself as well so I  
6 can attest to the ease.

7           When it comes to electing the service credit  
8 purchase, our members are now able to do so online, and  
9 that eliminates the paper-generated election packet and  
10 associated postage costs. In the first month after  
11 implementation, 45 percent of all elections were  
12 electronically submitted by members. And then they're  
13 able to make payments using our electronic payment  
14 gateway, eliminating the checks -- eliminating the need  
15 for paper checks to be mailed to us. So they can chose to  
16 pay by credit card, or ACH deduction from their bank  
17 account.

18           As we begun planning for next fiscal year, we're  
19 looking at additional customer service enhancements and  
20 providing more tools and online resources for our members.

21           Before I close, I just wanted to share a story  
22 about how our teams work to assist our public servants in  
23 times of tragedy. Whenever our Survivor Benefits team is  
24 alerted about a tragic event involving any public servant  
25 who might be a CalPERS member, the team reviews all

1 available information so they can provide the best service  
2 possible to the employer and to the survivors to  
3 facilitate the processing of benefits.

4           When the team learned of the recent shooting  
5 involving the Santa Clara Valley Transportation Authority  
6 in San Jose, they reviewed the accounts and contracts of  
7 each of the public servants. And while most of the  
8 victims were part of a different retirement plan offered  
9 by the agency, we did identify one victim as a CalPERS  
10 member. We were able to work closely with the VTA and the  
11 member's family to process those benefits. Unfortunately,  
12 this isn't the only tragic event of this kind this year.

13           Just this year, we've experienced other officer  
14 deaths in Santa Cruz, Stockton, and San Luis Obispo. And  
15 those were also immediately triaged in a similar fashion.  
16 While we hope these types of events are minimal, I am  
17 extremely thankful and proud of how this team handles  
18 these situations.

19           So much of our work right now is focused on the  
20 return-to-office plan and on what a hybrid team and  
21 telework environment looks like, and how we continue to  
22 focus on hybrid education so serve our customers. I want  
23 to again thank our team for all they've done to continue  
24 their exceptional customer service during these  
25 unprecedented times, and thank them for their patience and

1 understanding as we work through our return-to-office  
2 plan. And thank you to the Board for your continuous  
3 support.

4 That ends my presentation and I'm happy to take  
5 any questions.

6 CHAIRPERSON FECKNER: Thank you, Mr. Suine. And  
7 I, too, on behalf of the Committee, want to thank you and  
8 your staff for the exceptional customer service. I've  
9 heard during the pandemic times that customer service and  
10 response times have actually improved, so people are very,  
11 very proud to -- the call back work being done. So thank  
12 you and your team for a job well done. And we certainly  
13 hope that you don't have to do anymore of these fallen  
14 officers and members. It's been way too many this year.

15 Seeing no other requests, thank you. We'll move  
16 to Mr. Moulds.

17 DEPUTY EXECUTIVE OFFICER SUINE: Thank you.

18 CHIEF HEALTH DIRECTOR MOULDS: Good afternoon,  
19 Mr. Chair and members of the Committee. Don Moulds, Chief  
20 Health Director.

21 I'll start by sharing some good news. First,  
22 CalPERS and our own Dr. Logan were recently recognized as  
23 part of statewide collaborative efforts that decreased  
24 elective C-section rates. A study was just published in  
25 the Journal of the American Medical Association

1 highlighting how the collective work of several  
2 coordinated programs helped to reduce the number of  
3 C-sections for low-risk, first-time mothers. The study  
4 was lead by Stanford University School of Medicine and the  
5 California Maternal Quality Care Collaborative and  
6 examined efforts across the state between 2015 and 2019,  
7 and led to California becoming the first state in the  
8 country to achieve a sustained reduction in C-section  
9 rates.

10 CalPERS was involved through our prior strategic  
11 plan in collaboration with Smart Care California. And  
12 Julia was involved during her time at the Department of  
13 Health Care Services, where she worked on hospital  
14 incentive programs to decrease elective C-sections. This  
15 recognition demonstrates how our collective efforts with  
16 other purchasers can make a big impact.

17 The second piece of good news is that we are  
18 launching the first cohort of the CalPERS Health Care  
19 Academy this summer. The academy (inaudible) CalPERS team  
20 members to become more informed about health care markets,  
21 policy, purchasing trends, and their implications for  
22 CalPERS. Marian Mulkey, who you may recall delivered the  
23 health education session to the Board in January, created  
24 the curriculum and will lead the sessions.

25 This is all an outcome from the grant we received

1 last year from the California HealthCare Foundation to  
2 develop a health policy training curriculum for the Board  
3 and for our team. We're excited to kick off this first  
4 cohort later this summer and look forward to providing  
5 this excellent professional development opportunity to  
6 many more on the team.

7           Next, I want to provide a brief update on our  
8 long-term care communications. As you're aware, we mailed  
9 the notification letters about the rate increase to  
10 policyholders at the end of May. You can expect we've  
11 been receiving calls, and emails, and letters, as well as  
12 posts on CalPERS social media channels. We prepared for  
13 this. Our third-party administrator's call center added  
14 staff to handle the additional load and is reporting that  
15 the call center wait times are under a minute.

16           So far, their daily average number of calls is up  
17 about 23 percent from average, which is manageable. The  
18 offer letters to policyholders to modify their coverage to  
19 offset the rate increase will be mailed starting July  
20 26th. We expect to see high call volumes then and our  
21 staff to work with policyholders as they consider their  
22 offers.

23           Last, before I turn things over to Marta Green to  
24 lead us through the discussion of rates, I want to say a  
25 little bit more about spending trends. Going into this

1 year, we anticipated significantly higher than usual  
2 medical costs for 2022. Our projection at this point last  
3 year was that there would be a steep decline in  
4 utilization throughout 2020 that would last through the  
5 first quarter of 2021.

6 This was anticipated due to COVID restrictions.  
7 Recall that for significant portions of 2020, hospitals  
8 and other medical facilities were shuttered for in-person  
9 non-emergent care. Even when they were open, many people  
10 were electing to enter hospitals and doctor's offices.

11 We anticipated the decrease in utilization would  
12 be followed by a spike in utilization in the second half  
13 of 2021 and throughout 2022 as vaccines started coming  
14 online and our members were able to receive the routine  
15 care that they deferred during the worst parts of the  
16 pandemic.

17 While this is more or less the overall medical  
18 trend that we are seeing, it is far more modest than  
19 anticipated. The steep decline in utilization we saw in  
20 the spring of 2020 because of COVID returned to near  
21 normal levels far earlier than expected, particularly in  
22 our PPO. We still expect an increase in claims experience  
23 in 2022, as members seek delayed and deferred care, but  
24 our projections and the projections of our plans are that  
25 the increase will be far more modest than initially



1 expected.

2 More concerning are the pharmacy trends that  
3 we've been seeing headed into 2022. The overall price of  
4 drugs continued to increase in 2020 and drug rebates were  
5 generally lower. The transition to our new  
6 acquisition-based contract with our pharmaceutical benefit  
7 manager, OptumRx, has also been bumpy. Optum's initial  
8 rate submission for 2022 included increases that were well  
9 above trend. About four percent of that increase was  
10 attributable to an underprojection of 2020 utilization,  
11 with which we agree. However, a significant amount of the  
12 increase was due to initial disagreements between Optum  
13 and CalPERS about the way in which our savings guarantees  
14 in the new contract were intended to work.

15 After reviewing and rejecting multiple subsequent  
16 Optum proposals, CalPERS moved forward last week with its  
17 own rate. Marta will go into much more detail, but our  
18 own projection is closer to typical pharmaceutical cost  
19 growth, plus the four percent we need to account for in  
20 (inaudible) projections.

21 Encouragingly, Optum recently submitted a revised  
22 rate that is close to the CalPERS projection. That's the  
23 good news. The bad news is that we are very far off from  
24 what we want to be paying for pharmaceuticals. And for at  
25 least this year, the new acquisition price-based contract

1 we have with Optum doesn't appear to be realizing the  
2 savings we had hoped for. As I said, Marta is going to go  
3 into much more detail on both the medical and pharmacy  
4 trends. I want to thank her for leading a good discussion  
5 this morning in closed session, as well as for the hour  
6 plus discussion she led with our stakeholders that  
7 concluded earlier this morning. Her and her team have  
8 been burning the midnight oil, as they say.

9 That concludes my remarks. I am happy to answer  
10 any questions now. Otherwise, Marta and I will be both be  
11 around at the conclusion of her presentation.

12 CHAIRPERSON FECKNER: Thank you. I see no  
13 requests to speak from the Board -- or the committee.  
14 However, I understand that we have some public comment.

15 Mr. Fox.

16 STAKEHOLDER RELATIONS CHIEF FOX: Yes, Mr. Chair.  
17 We have four persons wanting to speak to long-term care.  
18 The first of which will be Tim Behrens, CSR.

19 MR. BEHRENS: Thank you, sir. Chairman Feckner  
20 members of the committee. Tim Behrens, President of the  
21 California State Retirees. I'd like to speak about the  
22 continued increase in long-term care. Over the last few  
23 months, and since the rate increase letters were received,  
24 I have begun getting a lot of numbers of members  
25 contacting me and indicating that they can't afford such a

1 large premium increase on top of a prior large increase,  
2 and are likely to cancel their long-term care policy.

3 To retain the same premium, they are concerned  
4 they will be getting a much interior policy coverage. CSR  
5 has commented to the Board two prior occasions requesting  
6 staff to do a new actuarial analysis with more current  
7 data based on the impacts of COVID-19. Almost all the  
8 current data in the commercial LTC market suggests the  
9 combination of high mortality and skilled nursing homes,  
10 high mortality in the elder population not yet in  
11 long-term care, and the reluctance of those who need  
12 skilled nursing, but avoided it out of fear have  
13 contributed to much lower costs for long-term care funds.

14 We have no expectations any longer that CalPERS  
15 might reduce the 52 percent increase they're implementing  
16 at this time. But based on that data that's lagging about  
17 six months behind and the new data of how many people will  
18 actually drop their long-term care policies, we hope to  
19 see that the 25 percent increase will be eliminated next  
20 year.

21 Thank you.

22 CHAIRPERSON FECKNER: Thank you.

23 Mr. Fox, please.

24 STAKEHOLDER RELATIONS CHIEF FOX: Yes. The next  
25 caller is Larry Woodson with CSR.

1 MR. WOODSON: Good afternoon. Larry Woodson  
2 Chair of the Health Benefits Committee, CSR. Can you hear  
3 me okay?

4 CHAIRPERSON FECKNER: Yes, sir.

5 MR. WOODSON: Okay. I'd like to thank you,  
6 Chairman Feckner, for the opportunity to comment. I'm  
7 commenting as well on the long-term care letters and the  
8 FAQs. I, too, received calls and emails from our members  
9 regarding the huge increase. Some were dropping that I've  
10 talked to, some after spending thousands of dollars over  
11 20 years or more. And if more numbers of people do drop,  
12 the high lapse rate would represent a boost to the  
13 financed, of course. And since it would retain millions  
14 and not have to fund any of those members long-term care.  
15 And I've heard from some members they're very cynical that  
16 that may be the motivation behind this and I don't believe  
17 that, but that is out there.

18 I'm advising members to wait and see what  
19 individual offers are made to them. I thought it would be  
20 in August. It sounds like it's in late July now to retain  
21 the same premiums with reduced benefits. The letter of  
22 rate increase I received included the FAQ that explained  
23 the increases and the process, but it contained what I  
24 consider a highly inaccurate statement.

25 It Says quote, "The CalPERS Long-Term Care Fund

1 is 69 percent funded and faces a shortfall of \$2.1  
2 billion". And I emphasize "is", because that is based on  
3 a valuation report with two-year old data. And the latest  
4 status of the fund, which I obtained from Mr. Bienvenue  
5 recently shows an increase in that fund with total assets  
6 an increase of 12 percent over that time. And it really  
7 should be about a \$1.4 billion shortfall not 2.1.

8 And combining that -- the higher fund assets now  
9 with lower claims due to COVID, higher mortality in  
10 nursing homes, skilled nursing centers, the costs should  
11 have been greatly reduced and the fund in much better  
12 shape. Now even the 2019 valuation report shows an  
13 investment run of 7.1 percent, well over the 5.25 discount  
14 rate, which was at the time. And it remains puzzling to  
15 my why the discount rate was lowered to 4.75. That  
16 lowering was a large driver of the 52 percent increase.

17 Finally, CSR has no illusions that the 52 percent  
18 increase will be lowered, but we submit that there is  
19 ample current data available, including higher returns  
20 from global equity over the last year, which is the second  
21 highest asset class for the fund to prevent any increase  
22 next year. And we submit there's justification for  
23 actually lowering the premium next year.

24 Thank you for your time.

25 CHAIRPERSON FECKNER: Thank you.

1 Mr. Fox.

2 STAKEHOLDER RELATIONS CHIEF FOX: Mr. Chair, the  
3 next speaker is Mr. Lawrence Grossman.

4 MR. GROSSMAN: Mr. Chair, members of the  
5 Committee, my name is Lawrence Grossman. I'm a CalPERS  
6 long-term care policyholder.

7 The premium on my policy since 2002 has increased  
8 421 percent. The contract stated that the premium was  
9 designed and partly guaranteed not to increase. Now,  
10 CalPERS is raising premiums another 90 percent, and my  
11 premium will be 890 percent higher than at inception.

12 My policy I believe is exemplary of about a  
13 hundred thousand policies. Though CalPERS explains that  
14 these increases are normal for the industry and legal,  
15 those assertions are not accurate. During the past two  
16 decades, the federal long-term care insurance program  
17 reports rate increases of no more than 157 percent.  
18 Commercial insurers in California such as Mutual of Omaha,  
19 Transamerica, Thrivent report increases no greater than 59  
20 percent.

21 Two court rulings have declared that significant  
22 parts of past CalPERS rate increases violate policy  
23 contracts.

24 CalPERS Long-Term Care Insurance Program is, in  
25 my estimation, substantively insolvent. CalPERS refusal

1 to recognize this has led to a cruel and cynical strategy  
2 of extorting elderly policyholders. CalPERS gets away  
3 with this only because it is unregulated.

4 This abusive behavior is precisely why insurance  
5 companies are normally regulated. If CalPERS Long-Term  
6 Care Program were a commercial insurance policy, by now  
7 the Department of Insurance surely would have declared it  
8 insolvent and placed it into receivership. But buyers of  
9 these policies were never told, unlike regulated insurers,  
10 CalPERS is shielded from consumer protection oversight by  
11 the Department of Insurance, including approval of rate  
12 increases, and is not financially backed by State  
13 insurance guarantee associations that assist policyholders  
14 when insurers go bankrupt. Moreover, contrary to the  
15 understanding of policy buyers, there was no disclosure  
16 that CalPERS, as a whole, is not financially backing the  
17 program.

18 At this Committee's November 2020 meeting,  
19 approving premium increases, there was no opposition and  
20 no substantive discussion. Today, I challenge each of you  
21 Board members to explain your votes by addressing these  
22 four questions. Why are these rate increases fair to  
23 policyholders? Why have CalPERS premium increases been  
24 vastly greater than those of other carriers? Why did this  
25 Committee not oppose nor did anyone not oppose the premium

1 increase in light of the court decisions? And finally,  
2 why did CalPERS fail to disclose vital financial stability  
3 information to policyholders?

4 At this point, this is what I think CalPERS needs  
5 to do, to acknowledge the program is insolvent, halt the  
6 premium increases, implement an independent program  
7 assessment, and four, call on the State to rescue the  
8 program. State legislation created the program and now  
9 the State should protect policyholders that they strongly  
10 encouraged to buy these CalPERS policies.

11 For additional information, please Google the  
12 words "CalPERS" and "Grossman" and you will find articles  
13 in detail that I have written on this subject.

14 Thank you very much.

15 CHAIRPERSON FECKNER: Thank you.

16 Mr. Fox.

17 STAKEHOLDER RELATIONS CHIEF FOX: Yes, Mr. Chair.  
18 The final caller on this subject is Alvin Barrett.

19 MR. BARRETT: Good afternoon.

20 CHAIRPERSON FECKNER: Good afternoon.

21 MR. BARRETT: I'm Alvin Barrett. Thank you for  
22 listening. Thank you for taking my call.

23 I have been a long-term care premium payer since  
24 2004. My wife has been a long-term care premium payer for  
25 26 years. Both of us have a substantial investment in the



1 plan. When my wife subscribed, she was not told that her  
2 premiums were likely to increase, and they have increased  
3 several hundred percent over the time while she's been  
4 paying them.

5 We are faced with a prospect of another 52  
6 percent increase. And these increases have been based on  
7 assumptions that we think are very questionable. This  
8 leaves us with a gristly choice of choosing between  
9 medical indications, were we to need the services or  
10 having to abandon our substantial investment.

11 We wish that you would analyze and reanalyze your  
12 assumptions. Your actuarial assumptions do not seem to be  
13 based upon recent experience with the pandemic and  
14 following that trend. We think that the -- there are  
15 fewer persons relying upon nursing home treatment since  
16 the onset of the pandemic. We think the mortality rate  
17 has increased and probably will leave you with some  
18 benefits unclaimed.

19 These circumstances lead to a conclusion that the  
20 cost should be lower than assumed under your actuarial  
21 analysis. We expect, in fact, a decrease in utilization  
22 in the near future, rather than a more modest increase.  
23 We ask you to authorize an internal audit that would bring  
24 light on your actuarial assumptions and permit us to  
25 determine what likely ought to be done with our

1 substantial investment in the future.

2 Thank you for your attention.

3 CHAIRPERSON FECKNER: Thank you.

4 Ms. Brown.

5 COMMITTEE MEMBER BROWN: Thank you, Mr. Chair.

6 You know, for the record, I did not support the  
7 increase back in November, but I also did not vote no. I  
8 abstained, because I knew what a hardship this increase  
9 was going to be. I really do -- and at that time, or  
10 maybe I did in April, asked for an update to the actuarial  
11 assumptions to see if we could lower some of the costs.

12 Since that time, I have read a number of Mr.  
13 Grossman's papers he's written and I have talked to him.  
14 And I believe I agree with Mr. Grossman about what CalPERS  
15 next steps should be, that we should get some help. We  
16 should ask the Legislature to -- for help, and we should  
17 delay the 52, 53 percent increase.

18 We are giving our policyholders -- and we're  
19 putting them in an untenable situation. And I think we  
20 need to relook at how we're handling this. I don't know  
21 if there's going to be a second on any of this or if this  
22 is even a motion, but I really think we need to do  
23 something different and go in a different direction.

24 Thank you.

25 CHAIRPERSON FECKNER: Thank you.

1 I understand we have one more caller, Mr. Fox.

2 STAKEHOLDER RELATIONS CHIEF FOX: Yes, Mr. Chair.

3 We have one more caller on this subject. Susan Cohen.

4 MS. COHEN: Hi. My name is Susan Cohen. I'm a  
5 CalPERS retiree and I really appreciate your time in  
6 allowing me to present today. My comments will be very  
7 brief. I was a county department head, which means I was  
8 fairly well paid when the offer came to me in my late 40s.  
9 Two companies were offered, CalPERS' and a private  
10 company. I thought, well, CalPERS -- of course, I want  
11 the CalPERS Long-Term Care Program. I don't have  
12 children. Why would I, if I did, burden them with my care  
13 anyway, I paid extra for the COLA increases.

14 In 2013, the 86 percent increase was shocking,  
15 but I stayed with it. You know, it's CalPERS. Don't we  
16 all believe in CalPERS? I don't know what the details of  
17 the analysis that CalPERS did then were, but I do believe  
18 that you're repeating yourself. I believe that the rate  
19 increases are cruel. They don't lineup with the  
20 contracts. They're really unfathomable, inexcusable. I  
21 don't think it's professional.

22 Larry -- Lawrence Grossman already spoke about  
23 the Department of Insurance review, but I want to  
24 personalize it. Besides that CalPERS long-term care isn't  
25 regulated like all other long-term care programs, it is an

1 unfair business practice. And so just to personalize it,  
2 and I won't be speaking much longer, I am looking at, at  
3 this rate of increase, 100 -- and I was a department head,  
4 so I was, you know, not the most high paid, but I was  
5 doing pretty good, I am looking at a hundred percent of my  
6 retiree income being needed to pay the premium when I turn  
7 age 91.

8           Now, I'm the daughter of a hundred year old  
9 mother. I may not live that long, but should I be so  
10 lucky, and should I live in assisted living sometime after  
11 that, I will tell you that the premium will cover -- well,  
12 obviously if I'm on claim, I won't pay a premium. But the  
13 premium up to that point will take 100 percent of my  
14 retiree paycheck. And if I'm on claim, the benefit will  
15 cover half of my cost of assisted living, but I won't have  
16 an income.

17           I believe that your continuation of this program,  
18 as you're running it, is immoral. I think it questions  
19 your ability to show respect to retirees. And I am only  
20 pushing 70. The people who are 80 and 90 are really in a  
21 pickle. I believe that there should be an independent  
22 review. I do not know what all the costs are that your  
23 Long-Term Care Program has all the costs. And I believe  
24 that the rate increases should be fully transparent and  
25 all of the costs should be revealed.

1           And I thank you very much for your time and  
2 attention.

3           CHAIRPERSON FECKNER: Thank you.

4           Any other callers, Mr. Fox?

5           STAKEHOLDER RELATIONS CHIEF FOX: No, Mr. Chair.  
6 That concludes comment on item 3.

7           CHAIRPERSON FECKNER: Thank you.

8           That takes us to Item 4, action consent items.  
9 We have one item in front of us, that's the approval of  
10 the March 16th meeting minutes. What's the pleasure of  
11 the Committee?

12           COMMITTEE MEMBER MILLER: Move approval.

13           COMMITTEE MEMBER BROWN: Second.

14           CHAIRPERSON FECKNER: Moved by Mr. Miller,  
15 seconded by Ms. Brown.

16           Any discussion on the motion?

17           Seeing none.

18           Ms. Hopper, please call the roll.

19           COMMITTEE SECRETARY HOPPER: Margaret Brown?

20           COMMITTEE MEMBER BROWN: Aye.

21           COMMITTEE SECRETARY HOPPER: Henry Jones?

22           COMMITTEE MEMBER JONES: Aye.

23           COMMITTEE SECRETARY HOPPER: David Miller?

24           COMMITTEE MEMBER MILLER: Aye.

25           COMMITTEE SECRETARY HOPPER: Nicole Griffith for

1 Eraina Ortega?

2 ACTING COMMITTEE MEMBER GRIFFITH: Aye.

3 COMMITTEE SECRETARY HOPPER: Ramon Rubalcava?

4 VICE CHAIRPERSON RUBALCAVA: Aye.

5 COMMITTEE SECRETARY HOPPER: Theresa Taylor?

6 COMMITTEE MEMBER TAYLOR: Aye.

7 COMMITTEE SECRETARY HOPPER: Shawnda Westly?

8 COMMITTEE MEMBER WESTLY: Aye.

9 COMMITTEE SECRETARY HOPPER: Karen Greene-Ross

10 for Betty Yee?

11 ACTING COMMITTEE MEMBER GREENE-ROSS: Aye.

12 COMMITTEE SECRETARY HOPPER: Mr. Chair, I have  
13 all ayes for Agenda Item 4a, March 16th, 2021 Pension and  
14 Health meeting minutes, motion made by David Miller,  
15 seconded by Margaret Brown.

16 CHAIRPERSON FECKNER: Thank you.

17 Agenda Item 5 is information consent items.

18 Having no requests to move anything, we will move to Item  
19 6, information agenda items.

20 6a, Preliminary 2022 Health Maintenance  
21 Organization and Preferred Provider Plan Rates.

22 Mr. Moulds.

23 CHIEF HEALTH DIRECTOR MOULDS: Thank you, Mr.

24 Chair. I'm going to turn things over to Ms. Green to lead  
25 us through the discussion of the 2022 rates.

1 (Thereupon a slide presentation.)

2 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION

3 CHIEF GREEN: Thank you, Dr. Moulds. And, good afternoon,  
4 Mr. Chair and members of the committee. Marta Green,  
5 CalPERS team member.

6 Next slide, please.

7 --o0o--

8 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION

9 CHIEF GREEN: Here is today's agenda. I'll review program  
10 updates for the 2022 plan year, the rate development  
11 timeline, discuss the weighted average preliminary premium  
12 changes, and explain the 2022 cost influencers, and  
13 present the preliminary premiums for the HMO and PPO  
14 plans.

15 Next slide, please.

16 --o0o--

17 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION

18 CHIEF GREEN: I'll begin with a review of the number of  
19 changes approved for the 2022 plan year. First, CalPERS's  
20 portfolio rating, the basic portfolio. This change is a  
21 result of a year-long analysis to manage risk and  
22 stabilize the basic plan portfolio. Plans will be priced  
23 based on their risk -- or, excuse me, plans will be priced  
24 base on their value rather than their concentration of  
25 healthier or unhealthy lives. We are implementing it as a

1 two-year phase-in.

2 As a reminder, Medicare plans are not included in  
3 portfolio rating, as the Medicare program is already risk  
4 adjusted. Further, the PPO program is moving from a  
5 three-plan model to a two-plan model, PERS platinum, and  
6 PERS Gold. Additionally, the Board approved new plans,  
7 service area expansions, and supplemental benefits.

8 In the basic portfolio, UnitedHealthcare is  
9 offering a new HMO product called Harmony, Blue Shield is  
10 expanding Access+, EPO, and Trio, and Western Health  
11 Advantage is expanding its HMO product.

12 In the Medicare Program, we have three new  
13 Medicare Advantage plans from Blue Shield,  
14 UnitedHealthcare and Western Health Advantage. Anthem  
15 Medicare Preferred is expanding their service area  
16 statewide. Additionally, back in November, the Board  
17 approved UnitedHealthcare's proposal to reduce to zero  
18 copays for many services, including emergency room visits.  
19 CalPERS gave the other health plan carriers an opportunity  
20 to propose changes to their Medicare copays for 2022.  
21 Blue Shield, Sharp, and Western Health Advantage proposed  
22 \$0 copays for their Medicare plans, except for emergency  
23 room visits. The emergency room copays will remain  
24 unchanged for these plans at \$50 per visit.

25 Next slide, please.



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HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION

1  
2  
3 CHIEF GREEN: Here is the rate development timeline for  
4 the 2022 plan year. As mentioned, last November, the  
5 Board approved the new risk mitigation strategies for the  
6 CalPERS Basic portfolio. And in November -- in March --  
7 and in March the results of the competition model approved  
8 new -- excuse me, approved new plans and service area  
9 expansions for both the Basic and Medicare products.

10           In May closed session, we presented you the  
11 initial premiums for 2022. Today, I'll present the 2022  
12 preliminary premiums, which included the new program  
13 changes. Between now and July, the CalPERS team will  
14 continue to verify that all rates reasonably reflect the  
15 cost of benefits provided. Final premium will be  
16 presented to the board for approval at the July off-site.

17           Next slide, please.

--o0o--

HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION

18  
19 CHIEF GREEN: Let's start with the basic HMO plans. As I  
20 mentioned, these premiums are portfolio rated with a  
21 two-year phase-in beginning in 2022. The CalPERS risk  
22 mitigation process uses a front-end premium adjustment  
23 process that is revenue neutral. Therefore, portfolio  
24 rating has no overall premium impact to the basic program.  
25

1 We also applied Health Care Fund premium adjustments based  
2 on our Health Care Fund Reserve Policy.

3 In the table, you will see the preliminary 2022  
4 proposed premiums for Basic HMO plans with and without the  
5 recommended Health Care Fund adjustments. Overall, Basic  
6 HMO plans have a 5.53 percent premium increase before  
7 applying Health Care Funded adjustments, and a 4.83  
8 percent with Health Care Fund adjustments.

9 UnitedHealthcare's Harmony is a new plan, so it is not  
10 included in the overall premium increase. More details  
11 will be discussed on the plan-specific slides.

12 I also want to address the adjustment period we  
13 are seeing as we transition to portfolio rating. As I  
14 mentioned before, the overall process of rating risk  
15 neutrally is revenue neutral, which means it has no  
16 overall impact to the portfolio. But what it does do is  
17 address pricing in individual plans. Those products that  
18 have seen skyrocketing costs year over year will reduce or  
19 moderate, while those that are chronically underpriced,  
20 well below the cost of health care and below the State  
21 contribution will increase this year.

22 But even with these increases, products like  
23 Salud y Más will re -- will remain below the State  
24 contribution and hundreds below Kaiser often cited as our  
25 benchmark plan. Once portfolio rating is fully

1 implemented in 2023, we can anticipate smooth and  
2 predictable changes across the portfolio as adverse  
3 selection is fully mitigated.

4 Next slide, please.

5 --o0o--

6 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION

7 CHIEF GREEN: For the Basic PPO plans, this table shows  
8 the premium changes from PERSCare and PERS Choice to PERS  
9 Platinum and from PERS Select to PERS Gold. Overall,  
10 Basic PPO plans have a 10.96 percent increase and an 8.31  
11 percent increase with Health Care Fund adjustments. For  
12 additional context, the PERS Platinum premium with Health  
13 Care Fund adjustment is about \$29, or three percent, lower  
14 compared to what we presented in November when the Risk  
15 Mitigation Strategy was approved. The PERS Gold premium  
16 is \$4, or 0.6 percent, lower.

17 As you can see, the PPO increases are  
18 significantly higher than the HMO. And there are several  
19 contributing factors, including fee-for-service medical  
20 trend and pharmaceutical costs. I'll get into more detail  
21 on later slides.

22 Next slide, please.

23 --o0o--

24 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION

25 CHIEF GREEN: For the Medicare Advantage plans, we have

1 three new plans starting in 2022. For the existing plans,  
2 we see an overall decrease of 6.11 percent and a 6.40  
3 percent decrease with the recommended Health Care Fund  
4 adjustment for Anthem Medicare Preferred.

5 I'll note here that the increase for Sharp's  
6 Medicare plan is due to the small plan size. It has only  
7 68 members and it's pricing will stabilize as the plan  
8 size grows. It remains the lowest cost Medicare Advantage  
9 product in the portfolio.

10 Next slide, please.

11 --o0o--

12 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION

13 CHIEF GREEN: The Medicare Supplement plans see an overall  
14 premium increase of 10.07 percent without Health Care Fund  
15 adjustments and 6.16 percent with recommended Health Care  
16 Fund adjustments.

17 Next slide, please.

18 --o0o--

19 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION

20 CHIEF GREEN: For the overall program, preliminary  
21 premiums have a 6.21 percent increase, and with the  
22 recommended Health Care Fund adjustments, a 4.92 percent  
23 increase.

24 Next slide, please.

25 --o0o--

## HEALTH PLAN RESEARCH &amp; ADMINISTRATION DIVISION

1  
2 CHIEF GREEN: I want to talk about a few highlights that  
3 are impacting health care costs in our program. First,  
4 I'll update you on the COVID experience in 2020 and the  
5 expectations for 2021 and 2022. Then I'll talk about the  
6 preliminary pharmacy increases for 2022. Lastly, I will  
7 give you an overview of the high level cost drivers in the  
8 premium change compared to 2021.

9 In 2020, COVID-19 introduced significant  
10 uncertainty regarding health care costs and rate  
11 development. Both CalPERS HMO and PPO plans followed  
12 similar patterns for the monthly COVID-related costs,  
13 including testing and treatment.

14 COVID-19 cases and their associated costs began  
15 in mid-March and peaked toward the end of July. Costs  
16 decreased until around October, at which point we saw a  
17 second surge in COVID-related costs throughout winter  
18 2020. There was not as much fee-for-service savings in  
19 2020 as we expected during the 2021 rate development  
20 process.

21 For many plans, part of the savings realized on  
22 Medicare claims was neutralized by the unexpectedly high  
23 pharmacy costs. Most of the health plans expect that  
24 services will return to normal levels at some point in  
25 2021. About 70 percent of eligible Californians, and

1 eligible is over the age of 12, have received at least one  
2 does of the COVID-19 vaccine. The vaccine itself is  
3 covered by the federal government and the administration  
4 costs are covered by health plans.

5           It is possible that the deferred care in the  
6 first half of 2021 will offset vaccine and other  
7 COVID-related costs. No significant COVID-related health  
8 care costs are expected in 2022. A booster shot may be  
9 released sometime in the fall of '21 or 2022 to supplement  
10 the vaccine, but these costs should be immaterial.  
11 However, we do anticipate additional utilization from  
12 delayed and deferred care into 2022.

13           Now, regarding pharmacy, utilization and trend  
14 came in significantly higher than what was projected for  
15 the 2021 plan year for a couple of reasons that Dr. Moulds  
16 discussed in his opening remarks. Most notably,  
17 utilization for the 2021 plan year is showing that we  
18 underprojected pharmacy costs for this year. Further,  
19 under the new acquisition-based contract, when Optum filed  
20 its rate proposal for the 2022 plan year, it did not  
21 accurately account for all of the appropriate contract  
22 provisions.

23           As a result, the team had to use its external  
24 pharmacy actuarial consultant to build the rate consistent  
25 with these contractual requirements. We are working with

1 Optum to address its submission. And although, we don't  
2 anticipate the overall pharmacy rate to change  
3 significantly between June and July, we do anticipate some  
4 adjustment in individual plan pharmacy rates when we  
5 present final premiums in July.

6 So the chart to the right shows the cost drivers  
7 for the overall 2022 premiums compared to 2021. In  
8 addition to the pharmacy increase, 2.8 percent accounted  
9 for medical inflation, 2.16 came in from the snapback from  
10 the 2021 Health Care Fund premium buydown adjustments.  
11 This adds up to a total of 6.21 percent increase before  
12 the recommended Health Care Fund premium buydown  
13 adjustment for 2022. The premium change would be 4.92  
14 percent with Health Care Fund adjustments.

15 Next slide, please.

16 --o0o--

17 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION  
18 CHIEF GREEN: With the recommended Health Care Fund  
19 adjustments, the overall premium increase is 4.83 percent.  
20 The overall premium -- PPO premium increase is 8.31  
21 percent. Comparing this to Mercer-Oliver Wyman trend  
22 benchmark from the January 2021 health care report, for  
23 the preliminary premiums, the HMO portfolio came in  
24 significantly lower than the national benchmark. The  
25 overall program increase of 4.92 percent also

1 significantly beat the national benchmark.

2           However, the PPO portfolio came in higher than  
3 the national benchmarks. The reason the PPO came in  
4 higher is driven by a few issues. One, the high cost  
5 areas of California that are only served by the PPO, two,  
6 the fee-for-service medical trend, and three, the pharmacy  
7 issues we just covered. I'll discuss in more detail the  
8 cost drivers in the PPO when we discuss those plans  
9 individually.

10           Next slide, please.

11                           --o0o--

12           HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION

13 CHIEF GREEN: I'm going to walk through each plan and  
14 discuss each element of its proposed premium starting with  
15 the HMO plans. The 2022 Basic HMO premiums are portfolio  
16 rated using the MARA prospective risk scoring tool with a  
17 two-year phase-in. The risk-neutral premium for a health  
18 plan is set by taking the average risk score for the  
19 members enrolled in that plan and removing that risk from  
20 the plan's medical and pharmacy costs.

21           As a reminder, a risk score is a measure of how  
22 costly an individual's medical needs are compared to the  
23 average population. A CalPERS member with a risk score of  
24 1.00 means that person's medical costs are at the level of  
25 an average person in the CalPERS Basic program.



1 Similarly, a risk score lower or higher than one, means  
2 that the person's medical costs are lower or higher than  
3 the average.

4           The risk scores are adjusted to account for  
5 volatility for plans with a small enrollment size. The  
6 credibility adjustment is applied to plan-level risk  
7 scores for those plans with involvement of less than  
8 25,000 members. HMO plans, subject to the adjustment, are  
9 Anthem Traditional, Blue Shield Trio, Health Net Salud y  
10 Más, Health Net SmartCare, Sharp, and Western Health  
11 Advantage.

12           Next slide, please.

13                           --oOo--

14           HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION

15 CHIEF GREEN: Let's start with Anthem Traditional. It's a  
16 broad network HMO and is offered in many of the high-cost  
17 low-competition areas of the state. On this slide, the  
18 first table on the top shows the 2021 premium, the  
19 preliminary proposed premium for 2022 before portfolio  
20 rating or the recommended Health Care Fund buydown  
21 adjustments, the change in dollars and percentage, as well  
22 as the total covered lives currently in the plan.

23           Before portfolio rating, the 2022 premium  
24 increase for Anthem Traditional was 13.19 percent. To the  
25 right of this table, we have a chart that shows the cost

1 drivers that led to the 2022 premium. Most of the premium  
2 increase came from a snapback from the 2021 premium  
3 buydown of 8.78 percent.

4 The middle table shows the risk score and the  
5 portfolio rating impact for the plan. Anthem Traditional  
6 has an average risk score of 1.2524. This indicates that  
7 the plan has a -- has sicker than average members in the  
8 Basic portfolio. In fact, Anthem Traditional is one of  
9 the plans with the higher risk scores in the portfolio.

10 With the credibility adjustment and two-year  
11 phase-in, the risk scored used in the 2022 premium is  
12 1.0880. Portfolio rating brought the premium down by 8.07  
13 percent to a 5.12 percent increase. The bottom table  
14 shows the team's recommendation to use surplus in the  
15 plan's Health Care Fund subaccount to buy down premiums.

16 For Anthem Traditional, the projected surplus is  
17 approximately 12.4 million as of December 2020. We  
18 recommend using 80 percent of the surplus to offset some  
19 of the premium impact to our members. This results in a  
20 1.26 percent premium decrease for 2022.

21 Next slide, please.

22 --o0o--

23 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION  
24 CHIEF GREEN: Anthem Select is narrow network plan with a  
25 strong presence in the Bay Area and Central Valley.

1 Anthem Select has a projected premium increase of 7.71  
2 percent. Higher than expected pharmacy costs have  
3 contributed to the overall increase -- premium increase by  
4 2.84 percent, compared to approximately one percent of  
5 normal pharmacy trend. The plan has a lower-than-average  
6 risk score, so portfolio rating has brought the premium up  
7 by an additional 2.53 percent for a total of 10.24 percent  
8 increase over 2021. The projected Health Care Fund  
9 surplus for this plan is approximately 13.1 million as of  
10 December 2020. Applying the same principal of using 80  
11 percent of the surplus to buy down the increase, we  
12 recommend reducing the premium increase to 7.72 percent.

13 Next slide, please.

14 --o0o--

15 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION

16 CHIEF GREEN: Blue Shield Access+ is a broad network HMO  
17 with populations concentrated in Sacramento and Los  
18 Angeles counties. For 2022, Blue Shield Access+ is  
19 reentering eight of the nine Bay Area counties they exited  
20 in 2019, all of those except Napa County. Blue Shield  
21 projected a modest premium change for 2022. Most of it is  
22 due to a snapback from the 2021 premium buydown.  
23 Portfolio rating has reduced the premium by 12.5 percent,  
24 leading to a decrease of 3.92 percent.

25 We don't recommend using Health Care Fund surplus

1 to bring the premium down further. We'd like to be  
2 conservative with the use of Health Care Fund surplus  
3 dollars to ensure availability of the fund to help  
4 mitigate any future premium volatility in this product.

5 Next slide, please.

6 --o0o--

7 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION

8 CHIEF GREEN: Blue Shield introduced Trio in 2020. The  
9 Board approved Trio's expansion of their service area into  
10 Orange, Santa Cruz, and Stanislaus counties for 2022.

11 Blue Shield is not moving forward with the  
12 Monterey County expansion due to challenges with provider  
13 contract negotiations. Trio had a 0.94 percent portfolio  
14 rating impact to their premium, leading to a 5.15 percent  
15 change in premium. We recommend using 80 percent of the  
16 Health Care Fund surplus to reduce the premium increase  
17 from 5.15 percent to 3.84 percent.

18 CalPERS will be adopting changes to the Trio  
19 formulary that are designed to address low-value  
20 prescriptions. These changes are consistent with  
21 formulary changes previously made in the OptumRx formulary  
22 and the net impact will be a two percent decrease in net  
23 pharmacy costs, which will translate to a 0.3 percent  
24 decrease in statewide premiums for Trio. This change will  
25 be included in the final proposed premiums in July.

1 Next slide, please.

2 --o0o--

3 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION

4 CHIEF GREEN: Health Net Salud y Más is a plan with a very  
5 narrow network that provides services to a small  
6 population in the lowest cost counties in California, Kern  
7 Los Angeles, Orange, Riverside, San Bernardino, and San  
8 Diego counties.

9 The projected premium before portfolio rating  
10 increased 9.09 percent, mainly driven by the  
11 underprojection of the 2021 medical costs due to COVID and  
12 the higher-than-expected pharmacy rate for 2022. In fact,  
13 Salud y Más had the highest COVID-related costs on a per  
14 member basis among all CalPERS Basic plans in 2020.

15 Salud y Más has a risk score of 0.6953, meaning  
16 the plan's members on average are about 30 percent  
17 healthier than the CalPERS average. With the credibility  
18 adjustment and two-year phase-in, Salud y Más received a  
19 12.55 percent portfolio rating impact to the premium,  
20 which led to the overall increase of 21.64 percent.

21 We recommend using 80 percent of the Health Care  
22 Fund surplus to reduce the premium increase from 21.64  
23 percent to 13.28 percent. Even with the premium increase  
24 in 2022, Salud y Más has by far the lowest HMO premium for  
25 the Basic portfolio and is 20 percent lower than the 80/80

1 State contribution \$607 for 2021.

2 Next slide, please.

3 --o0o--

4 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION

5 CHIEF GREEN: Health Net SmartCare is a standard network  
6 HMO operating in 20 counties. This plan has experienced  
7 volatile member migration patterns and risk concentration  
8 fluctuations in the past few years.

9 For 2022, smartCare had a 9.01 percent -- has a  
10 9.01 percent premium increase after the downward impact of  
11 portfolio rating. The main cost drivers are the  
12 higher-than-normal medical and pharmacy trends and the  
13 2.63 percent snapback from the 2021 premium buydown. The  
14 Health Care Fund subaccount for SmartCare is in a small  
15 deficit as of December 2020. Therefore, there is no  
16 premium buydown opportunity for SmartCare.

17 Next slice, please.

18 --o0o--

19 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION

20 CHIEF GREEN: Kaiser is a closed network fully insured HMO  
21 plan that carries all financial risk for services  
22 provided. It operates in 31 counties throughout the  
23 state. Kaiser proposed a premium increase of 2.68 percent  
24 for 2022. This is very modest and one of the lowest in  
25 the basic portfolio. Even though it is a very competitive

1 rate, we continue to analyze Kaiser's financial position  
2 to ensure that our members are getting the best deal we  
3 can negotiate.

4 Portfolio rating has brought the premium up by  
5 additional 2.97 percent leading to an overall premium  
6 increase of 5.65 percent. Because Kaiser is a fully  
7 insured plan, there is no opportunity to accrue a Health  
8 Care Fund balance.

9 Next slide, please.

10 --o0o--

11 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION

12 CHIEF GREEN: Sharp is a closed capitated provider network  
13 HMO that provide services to the San Diego area. The 2022  
14 preliminary premium increase is 5.01 percent. Sharp has a  
15 6.43 percent portfolio rating impact due to their lower  
16 risk concentration with premium increases 11.44 percent  
17 overall.

18 Keep in mind that sharp is one of the lowest cost  
19 plans within the portfolio, so even with this increase, it  
20 is still more than a hundred dollars below Kaiser.

21 The Health Care Fund account for Sharp is in a  
22 deficit as of December 2020. This is carried forward from  
23 the losses accumulated from the previous five-year  
24 contract. We anticipate the Health Care Fund deficit will  
25 recover slowly due to the flex-funded arrangement.

1 Therefore, there is no premium buydown opportunity for  
2 Sharp for 2022.

3 Next slide, please.

4 --o0o--

5 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION

6 CHIEF GREEN: UnitedHealthcare Alliance is a standard  
7 network HMO plan operating in 26 counties. The 2022  
8 preliminary premium increase, without Health Care Fund  
9 adjustment or portfolio rating is 9.73 percent. Alliance  
10 main cost drivers are medical costs, pharmacy costs, and  
11 2021 snapback. Alliance has a 1.28 percent portfolio  
12 rating impact to their premium for an overall 11.01  
13 percent increase in premium.

14 The team recommends using 80 percent of  
15 Alliance's Health Care Fund surplus to reduce the premium  
16 increase to 8.09 percent.

17 Next slide, please.

18 --o0o--

19 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION

20 CHIEF GREEN: UnitedHealthcare's SignatureValue Harmony is  
21 a new Basic HMO plan for 2022. Harmony is a narrow  
22 network plan in five Southern California counties, Los  
23 Angeles, Orange, Riverside, San Bernardino, and San Diego.  
24 The preliminary portfolio rated premium for 2022 is  
25 \$737.67 with a risk mitigation impact of 7.86 percent.



1 This is based on the projected risk level from the Bates  
2 White Economic Model.

3 The bar graph on the slide shows the HMO Basic  
4 plan's State premium. Harmony's preliminary premium came  
5 in the third lowest, mainly due to being in the lowest  
6 cost counties in Southern California. Harmony has a  
7 highly capitated model, which is expected to be more  
8 efficient and cost effective.

9 Next slide, please.

10 --o0o--

11 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION  
12 CHIEF GREEN: Western Health Advantage is a fully  
13 capitated provider model that services the Sacramento  
14 area. For 2022, Western Health Advantage will expand  
15 their basic HMO plan into Humboldt County. This plan is  
16 also interested in expanding its Medicare Advantage  
17 product into Humboldt in 2023, if it receives federal  
18 approval.

19 Western Health Advantage's service areas  
20 expansion will create the first low cost HMO available in  
21 Humboldt County and is great for our members. Western  
22 Health Advantage has a negative 2.21 percent portfolio  
23 rating impacting premium for an overall 1.93 percent  
24 increase in premium. We recommended using 80 percent of  
25 the Health Care Fund surplus to reduce the 1.9 percent

1 premium increase to a 1.5 percent decrease.

2 Next slide, please.

3 --o0o--

4 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION

5 CHIEF GREEN: Before we jump into the Medicare plans, I  
6 wanted to show the preliminary premium levels for each of  
7 the basic plans together as a portfolio. As you can see,  
8 there are still variation in price points as we transition  
9 towards portfolio rating.

10 Next slide, please.

11 --o0o--

12 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION

13 CHIEF GREEN: Anthem Medicare Preferred will expand their  
14 service area into an additional 21 counties, making it a  
15 statewide plan for 2022. Anthem is offering new benefit  
16 enhancements, a healthy pantry program, which offers  
17 nutritional counseling sessions, and non-emergency  
18 transportation.

19 In addition to the service area expansion and  
20 supplemental benefits we shared in November, Anthem is  
21 also offering to reduce the member out-of-pocket costs  
22 from 10 percent coinsurance to \$0 copay for durable  
23 medical equipment, continuous glucose monitors, diabetic  
24 supplies, including preferred brand blood glucose  
25 monitors, and diabetic therapeutic shoes and inserts with

1 no additional increase to the premium. Anthem Medicare  
2 Preferred has a modest premium increase of 1.75 percent  
3 for 2022.

4 I'll mention again here, Medicare plans are not  
5 included in portfolio rating as the Medicare Program is  
6 already risk adjusted.

7 The team recommends using 50 percent of the  
8 plan's Health Care Fund surplus dollars to reduce the  
9 preliminary proposed premium to \$357.70, for a 7. -- 6.7  
10 percent decrease from 2021. We would like to take a  
11 slightly conservative approach with using 50 percent of  
12 the Health Care Fund reserve, because this is relatively  
13 new plan that started in 2018 and enrollment has grown  
14 slowly ever since. We'd like to be conservative with the  
15 use of the Health Care Fund surplus dollars to ensure  
16 availability of funds in future years to mitigate any  
17 volatility in this plan's premium.

18 Next slide, please.

19 --o0o--

20 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION  
21 CHIEF GREEN: For Kaiser Senior Advantage, there are no  
22 benefit design or service area changes for 2022. The 2022  
23 preliminary premium is \$302.53. This is a 6.76 percent  
24 decrease from 2021. This is primarily driven due to an  
25 increase in CMS revenue.

1 Next slide, please.

2 --o0o--

3 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION

4 CHIEF GREEN: Sharp Direct Advantage Medicare was  
5 introduced in 2021. As I mentioned earlier for 2022,  
6 Sharp Direct Advantage will have \$0 copays for several  
7 services and the ER visit copay will remain unchanged at  
8 \$50 per visit.

9 Also, I want to note here, this plan has 68  
10 members enrolled, which is why we are seeing an increase.  
11 As more members enroll, the premium will stabilize.  
12 However, the 2022 preliminary premium of \$263.85 is the  
13 lowest premium in the CalPERS Medicare Program.

14 Next slide, please.

15 --o0o--

16 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION

17 CHIEF GREEN: There are no benefit design or service area  
18 changes for the UnitedHealthcare Group Medicare Advantage.  
19 The 2022 preliminary premium is \$294.65. This is a 5.43  
20 percent decrease from 2021, mainly due to increase in  
21 projected revenue from CMS.

22 Next slide, please.

23 --o0o--

24 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION

25 CHIEF GREEN: The table on this slide shows the

1 preliminary premiums for the new Medicare Advantage plans  
2 for 2022, Blue Shield Medicare PPO, UnitedHealthcare Edge,  
3 and Western Health Med -- Western Health Advantage  
4 Medicare Advantage.

5 I'm pleased to share news that Blue Shield  
6 Medicare Advantage plans approved by the Board in November  
7 will be available nationwide, not just statewide. This  
8 gives our retirees living out of state more choice to  
9 access care no matter where they live in the country.  
10 This nationwide expansion had no increase nor impact to  
11 the premium. The preliminary proposed premiums are  
12 displayed on the bar graph alongside the current Medicare  
13 Advantage plans we offer.

14 Next slide, please.

15 --o0o--

16 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION  
17 CHIEF GREEN: This is a little repetitive, but here you  
18 can see all of the preliminary premiums for the Medicare  
19 Advantage plans for the 2022 plan year.

20 Next slide, please.

21 --o0o--

22 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION  
23 CHIEF GREEN: Moving on to the PPO plans. As you may  
24 recall from our discussions of portfolio rating the PPO,  
25 it's performed a little bit differently than the HMO.

1 Unlike, the HMO plans with different carriers, the PPO  
2 plans are all administered by Anthem. They fall under the  
3 same business model, the same care management approaches,  
4 the same underlying provider contracting, and the same  
5 geographic footprint, which is the whole state.

6 This allows us to price the PERS Platinum and  
7 PERS Gold plans based on the value of the networks and the  
8 benefit differentials. I already discussed the general  
9 cost drivers across the portfolios. I'm going to spend a  
10 little bit more time here on why the PPO is experiencing  
11 higher premium increases than the HMO.

12 Without the requirements of choosing a primary  
13 care physician for specialist referrals, PPOs have  
14 relatively loose care management compared to HMOs. This  
15 results in higher utilization in services like outpatient,  
16 professional specialists, ambulatory surgery, and  
17 pharmacy, regardless of population risk.

18 PPO utilizations of these services are more than  
19 40 percent higher than the HMO. The capitation payment  
20 system used with the HMO creates a more cost efficient  
21 health care system compared to the PPO fee-for-service  
22 payment system. This results in lower unit cost for some  
23 services, such as inpatient, emergency room, and physician  
24 services than the HMO.

25 PPO plans cover out-of-network care that the HMO

1 plans do not. Out of network service cost is much higher  
2 than in-network, as there is no provider contract and no  
3 care management for out-of-network services. The unit  
4 cost for out-of-network inpatient hospital is more than 25  
5 percent higher than in-network inpatient hospitals.

6 And finally, based on 2019 experience, the  
7 overall health care cost for the Basic PPO members were  
8 roughly 18 percent higher than the Basic HMO average.

9 Next slide, please.

10 --o0o--

11 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION

12 CHIEF GREEN: As approved last November, the three PPO  
13 Basic plans will be replaced with two PPO Basic plans in  
14 2022, PERS Platinum and PERS Gold.

15 PERS Platinum has the same network and benefit  
16 designs to the current PERSCare plan and PERS Gold has the  
17 same network and benefit design to the current PERS Select  
18 plan.

19 You can see from the left top table, the PERS  
20 Platinum will have a 12.01 percent decrease from the 2021  
21 PERSCare premium and about a 15 percent increase from the  
22 2021 PERS Choice premium. This also accounts for the  
23 increase in benefits from the PERS Choice 80/20 plan to  
24 the PERS Platinum 90/10 design. The 2022 PERS Gold  
25 premium is about 22.92 percent higher than the 2021 PERS

1 Select premium.

2           The bar chart on the right shows the detailed  
3 breakdown of the cost drivers. The underprojection from  
4 the 2021 premium is carried forward. The higher-than-  
5 expected pharmacy costs contributed an additional 2.8  
6 percent to the premium increase. Combining these with the  
7 medical trend and the snapback from the 2021 premium  
8 buydown, we have a total increase of 10.96 percent for the  
9 overall PPO Basic program.

10           As a reminder, PPO Health Care Fund Reserve  
11 Policy states that premium adjustments may be considered  
12 when the fund balance actuarial reserve ratio falls below  
13 90 percent or exceeds 110 percent. As of December 2020,  
14 the combined ratio for PERS Choice and PERSCare is at 113  
15 percent. We recommend using 80 percent of Health Care  
16 Fund surplus to buy down the 2022 PERS Platinum premium to  
17 bring the ratio down to 103 percent, a much more prudent  
18 threshold.

19           The Health Care Fund account for PERS Select is  
20 in a deficit as of December 2020. The fund balance to  
21 actuarial reserves ratio falls below 90 percent. We don't  
22 recommend implementing a surcharge for 2022.

23           With the recommended premium buydown adjustment,  
24 the overall basic PPO premium increase will be reduced  
25 from 10.96 percent to 8.31 percent. As a reminder, the



1 PERS Platinum premium with Health Care Fund adjustment is  
2 about \$29, or three percent, lower compared to what we  
3 presented in November when the Risk Mitigation Strategy  
4 was approved. PERS Gold premium is about four dollars, or  
5 0.6, percent lower.

6 Next slide, please.

7 --o0o--

8 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION  
9 CHIEF GREEN: Just like the Basic plan, the current three  
10 PPO Medicare supplement plans will be replaced with two,  
11 PERS Platinum and PERS Gold Medicare Supplement. These  
12 plans have the same provider network throughout all 58  
13 counties. PERS Platinum will also be available for  
14 out-of-state members, while PERS Gold is exclusively for  
15 in-state members.

16 The benefits offered under PERS Platinum will be  
17 identical to the current PERSCare and nearly identical to  
18 the PERS Gold. PERS Platinum will only have slightly  
19 richer coverage over PERS Gold for hearing aids and other  
20 benefits that are beyond traditional Medicare coverage.

21 For 2022 PERS Platinum Medicare will increase  
22 about 6.22 percent from the 2021 PERSCare Medicare premium  
23 and about 15.71 percent from the 2021 PERS Choice Medicare  
24 premium. The 2022 PERS Gold premium is about 9.66 percent  
25 higher than the 2021 PERS Select premium.

1 Overall, we see a total increase of about 10.07  
2 percent in the PPO and Medicare supplemental plans, namely  
3 driven by an 8.81 percent snapback from the 2021 premium  
4 buydown. We recommend using 80 percent of the Health Care  
5 Fund surplus to reduce the premium increase from 10.07  
6 percent to 6.16 percent.

7 Next slide, please.

8 --o0o--

9 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION  
10 CHIEF GREEN: Here we show you the 2022 preliminary  
11 premiums for the total basic plan portfolio. You see here  
12 that monthly premiums range from \$1,205 to \$482.

13 Next slide, please.

14 --o0o--

15 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION  
16 CHIEF GREEN: And here are the 2022 preliminary premiums  
17 from the Medicare Advantage and Medicare Supplement plans  
18 ranging from \$386 to \$264.

19 Next slide, please.

20 --o0o--

21 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION  
22 CHIEF GREEN: For next steps, the CalPERS team will  
23 evaluate the plans' updated data, trends, and assumptions,  
24 and will continue negotiations. We will present final  
25 premiums in July for Board approval. The 2022 health

1 premiums will be effective on January 1st, 2022.

2 That concludes my presentation and I'm happy to  
3 take any questions.

4 CHAIRPERSON FECKNER: Thank you, Ms. Green.  
5 Thank you for a very concise presentation. Appreciate  
6 that. I also want to thank you and your entire team for  
7 all the work up to this point. I know that they took a  
8 lot of it on under your direction without you, while you  
9 were gone for a while. So thank all of them for putting  
10 their best foot forward.

11 I do want to say that the plans have heard me say  
12 in the past that I want you to come with sharper pencils.  
13 I'm not going to say that this year. What I'm going to  
14 say is, first of all, I'm going to say thank you to  
15 Western Health Advantage for the expansion into Humboldt.  
16 I think that gives our members a good opportunity up  
17 there. Also, I want to say thank you to the plans that  
18 have partnered with our staff so far this year.

19 But I'm also going to say that there appear to be  
20 a few that have not chosen to partner with our staff this  
21 year. And I encourage you to do so, to not only just  
22 partner with our staff, but partner on the other side with  
23 your hospitals and your provider networks out there, so  
24 you can come back with a better rate for us.

25 Our members have hurt this last year and it's

1 going to continue. We need to get to the best rate  
2 possible. And I need you to understand that this  
3 Committee has options. And they may or may not have chose  
4 to offer those in the past, but there are options on the  
5 table for us.

6 So come in July with your best numbers. Those  
7 that don't, I will probably call you out personally. I  
8 want to see this action take place.

9 So with that, I have a number of Board members  
10 that wish to speak and then we have quite a number of the  
11 public that wish to speak.

12 First, I have Mr. Rubalcava.

13 VICE CHAIRPERSON RUBALCAVA: Thank you, Mr.  
14 Feckner.

15 First, I do want to concur with your statements  
16 and thank you for saying that to -- for the general public  
17 and the carriers to hear. I do want to thank Ms. Green  
18 and her team. Excellent presentation.

19 I do have a question. All these rates are -- is  
20 a -- because -- is it because of risk -- new risk  
21 mitigation approach the portfolio rating. And a lot of  
22 that depends on adjusting the rates, so it's based on the  
23 value, not so much the risk. And so a clear point of that  
24 is calculating the risk factor, which is very key. And so  
25 it has interesting results on every plan and sometimes a

1 percentage increase or decrease is interesting, and can be  
2 taken out of context.

3 But I do want to thank you and commend you for  
4 doing this approach. I think this is the best way for  
5 people to see the value of benefit and it also diminishes  
6 the opportunity for trying to grab market just through  
7 having a plan design or a rate that would attract the best  
8 risk, I would say, the most -- the young invincibles, we  
9 used -- they used to call them.

10 But I do have a question. It is a two-year -- I  
11 have a couple questions. It's a two-year transition. So  
12 one of the things that's going to have, and we're going to  
13 hopefully see it -- we will -- we started seeing already  
14 for example Anthem Traditional and for Blue Cross Access+  
15 is there will be less volatility, there will be less  
16 snapback. So do we expect that trend to continue second  
17 year or it will be less subdued in the adjustments that  
18 would have to be done. That's the first question.

19 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION  
20 CHIEF GREEN: Yeah, what you'll see is a reduction in the  
21 member migration patterns and a reduction in the  
22 concentration of risk. And so that will be a smoothing in  
23 the premium adjustments year over year. So those that  
24 were -- that were completely flat and that were  
25 underpriced relative to their risk, those you'll start to

1 see to moderate an increase to the nominal price of health  
2 care. And those that were skyrocketing, because they were  
3 experiencing volatility due to adverse selection, those  
4 will moderate, so will either level off or will decrease.

5 Then you'll also see enrollment -- the enrollment  
6 shifts that we're happening, so people fleeing the high  
7 cost plans, which was sending them into a death spiral,  
8 that will moderate as well. And then once everything is  
9 priced risk neutrally, all of those patterns stabilize.

10 VICE CHAIRPERSON RUBALCAVA: Thank you. You say  
11 it so much better than me.

12 I had the note there to use the word "smoothing",  
13 but I forgot, but -- because that's something an actuary,  
14 you smooth the impact, not here, but '37 Act counties.

15 The other question is related to that, to some of  
16 the answers you gave. We have a couple narrow networks,  
17 quality providers, the best way to say it, and -- because  
18 they tend to be fully capitated -- mostly capitated or  
19 owned by the provider -- I'm sorry, by the carrier. And  
20 so that helps provide a higher quality care management.

21 We have the introduction of one, Harmony, new  
22 one. And I know -- my question is how did you get to the  
23 projected -- to the risk score? Because I notice, for  
24 example, the other one, Trio, has closer to average on the  
25 risk score so. I'm just curious how we got to that

1 number?

2 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION

3 CHIEF GREEN: So we use the Bates White economic model,  
4 which has a sophisticated member migration pattern that  
5 actually looks at all of our members and all of their risk  
6 scores, and where they will move as a result of the  
7 introduction of new products. So that's how we brought  
8 forth our recommendation of the approval of Harmony and  
9 it's how we mapped out their likely risk score.

10 VICE CHAIRPERSON RUBALCAVA: Thank you. That  
11 makes sense.

12 And my final question is regarding Kaiser. It's  
13 a full insured plan, so there's less adjustments that  
14 CalPERS has to do, but on the other hand, they assume the  
15 risk, I guess, all the --

16 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION

17 CHIEF GREEN: Yes.

18 VICE CHAIRPERSON RUBALCAVA: I guess it balances  
19 it out. So how would you think going forward we will see  
20 the -- will the same pattern happen to that plan as the  
21 other plans? Will we see a smoothing out of the rate,  
22 less up and down, less flex -- less volatility or would  
23 you --

24 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION

25 CHIEF GREEN: Yes and no. I mean, Kaiser's risk score

1 hovers right around 1, 1.0. I mean it's very close. It's  
2 slightly below 1 currently, but it is really close to 1.  
3 And some of that is because it is just so large within  
4 the -- in the portfolio. So something that is that big  
5 ends up kind of defining the middle of the portfolio just  
6 because it's so large. It ends up becoming kind of the  
7 average.

8           And so Kaiser hasn't in our portfolio, if you  
9 look at it over time, it has never seen those 10, and 15  
10 percent, and sometimes 20 percent increases that we saw  
11 like at the end of risk adjustment when you started seeing  
12 massive changes in the portfolio. So it just has never  
13 seen the level of volatility that some of our other  
14 products have seen.

15           But in general, yes, you will see kind of a  
16 leveling off of all of the products. But again, that --  
17 the volatility that has been in some of the other products  
18 has never actually existed in the Kaiser product.

19           VICE CHAIRPERSON RUBALCAVA: Thank you very much.  
20 And again, thank you for the work -- great work you did.  
21 And I want to commend you and the whole team for this new  
22 approach. It's -- on how to deal with risk mitigation.  
23 So thank you.

24           HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION  
25 CHIEF GREEN: Thank you.



1           VICE CHAIRPERSON RUBALCAVA: Thank you, Mr.  
2 Feckner.

3           CHAIRPERSON FECKNER: Thank you.  
4 Ms. Taylor.

5           COMMITTEE MEMBER TAYLOR: Thank you, Mr. Chair.  
6 And I do want to also thank the team for all the hard work  
7 that they've done. And I sort of want to repeat what Mr.  
8 Feckner said, which is we had some very cooperative  
9 partners in this and we had some that were not. And I'm  
10 asking them to come back to the table and work a little  
11 harder.

12           But I would also ask, and I've mentioned this  
13 before in open session, I think our carriers need to be  
14 working harder with the providers and networks to come up  
15 with better rates as well, because I know that they're  
16 passing on rates to us that come from the hospital and  
17 doctor networks et cetera. And I think that we really  
18 need to ask them to sit down with those providers, hammer  
19 out better deals, and then come to us with better deals,  
20 because a lot of -- I represent all State employees. I  
21 represent all CalPERS, but State employees took a 10  
22 percent pay cut and now we're asking for State employees  
23 to take a huge amount of their paycheck for health care.  
24 And this is becoming unsustainable for our employees.

25           And I think I speak for all of the employees,

1 whether they're my employees, or our local agencies, or  
2 even our retirees, these are unsustainable rate increases.

3           And there's a couple of questions I had. I know  
4 that the risk adjusting or smoothing is going to help us  
5 kind of stabilize everything. But as we buy down the  
6 rates every year, we cause a snapback. So as we're buying  
7 down this year, my first question is, what kind of impact  
8 is that going to have for next year?

9           HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION

10 CHIEF GREEN: So you will see some level of snapback from  
11 buydowns. It's part of the cycle that we want to get out  
12 of with the long-term portfolio rating strategy. With  
13 having the lack of stability in portfolio, this is why we  
14 had the expansion and contraction -- or one of the reasons  
15 we had the expansion and contraction in the Health Care  
16 Fund subaccounts that we were seeing over time.

17           And so by creating these smooth and predictable  
18 rates that -- for our members, we will also see more  
19 smooth and predictable Health Care Fund subaccounts. And  
20 so we will see much more modest adjustments with -- of the  
21 Health Care Fund subaccount buydowns, and then therefore  
22 snapbacks associated with those to be very, very small and  
23 observable.

24           But you will see some associated with these  
25 buydowns. Though many of these buydowns are more modest

1 than we have seen in recent years, though still a prudent  
2 thing to do to reduce the impact of rate creases for our  
3 members. But over time, this is what we want to get away  
4 from.

5 COMMITTEE MEMBER TAYLOR: I agree. I appreciate  
6 that. Yeah, I thought that might have an impact. And  
7 again, I just want to rerate, it is -- it is getting just  
8 imperative for us to find out any way we can to work with  
9 our carriers to bring these costs down. But in addition,  
10 I'm wondering if you could kind of go into -- and I know  
11 we covered this before, but I'm getting questions. So I'm  
12 wondering if you could go into some of our mitigation  
13 tactics that we've been trying to help costs lower or  
14 maintain costs, so they're not quite as high. If you  
15 could go into a few of the things that we've done this  
16 year and even before.

17 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION  
18 CHIEF GREEN: Yeah. So some of the tactics that we're  
19 really focused on right now is bringing lower cost, higher  
20 valued products into areas that don't have access to those  
21 products. And so one of the things that I'm really  
22 excited about is bringing those new products like the  
23 expansion of Western Health Advantage into Humboldt, the  
24 expansion of Trio. We're really encouraging our carriers  
25 with those high value networks, those networks that have

1 those providers that are efficient and effective at  
2 treating members at those lower price points into areas,  
3 so members have choice.

4           Some members may choose to remain with high cost  
5 providers. And we want members to have that choice. But  
6 at the same time, we want members to be able to choose  
7 more efficient and effective network -- networks at that  
8 lower price point. So really being able to bring  
9 effective, efficient networks to our members no matter  
10 where they live in the state is kind of our number one  
11 priority.

12           And then also getting a handle on these  
13 pharmaceutical costs, as we've talked about from the  
14 beginning of the presentation with Dr. Moulds' opening  
15 remarks and doing a better effective job in working with  
16 our PBM on those costs.

17           Those are the two I'd like to point to. Dr.  
18 Moulds, do you want to add anything?

19           CHIEF HEALTH DIRECTOR MOULDS: Those are -- those  
20 are the two that are top of my list for sure. You know,  
21 the other one is the -- is the broader competition study,  
22 which (inaudible) to create more competition in low  
23 competition or monopolistic areas. We were successful in  
24 doing that in Santa Barbara last year. We came very close  
25 to being able to do that in Monterey with Trio this

1 career. But ultimately, the price -- the negotiating  
2 price was going to result in an increase in overall State  
3 costs that we didn't want to subject members to.

4 We'll make another run at it. (Inaudible) we're  
5 talking to other plans about moving into areas with  
6 innovative options that do everything from, you know,  
7 trying to divert traffic from monopolistic hospitals into  
8 lower cost of care settings to just creating competition.  
9 You know, those are -- those are all longer term  
10 strategies.

11 Short term, and I'll just reiterate with Marta  
12 said, we want to get HMOs into these areas where right now  
13 the PPO is the only option. It is -- you know, PPOs are  
14 more expensive because -- for many reasons, including the  
15 fact that there's no managing of care. And if people want  
16 to pay more for a product like that, it's one thing. But  
17 when it is their only option, that's a problem.

18 So, you know, we've already started talking to a  
19 number of our plans about moving into some of these areas  
20 where the PPO is the only option to create a second option  
21 for 2023 and we'll continue those conversations right up  
22 until we're doing rates next year.

23 COMMITTEE MEMBER TAYLOR: I appreciate that. I  
24 wondered -- and I think you guys may have answered this  
25 question before is -- could the State be a partner in

1 driving, somehow or another, doctors to those areas  
2 through an education stipend of some kind?

3 CHIEF HEALTH DIRECTOR MOULDS: Yeah. You know,  
4 some of -- there are programs that exist to do that.  
5 (Inaudible).

6 COMMITTEE MEMBER TAYLOR: Uh-oh.

7 CHIEF HEALTH DIRECTOR MOULDS: (Inaudible) agency  
8 provides a heavy deferment of medical school that -- for  
9 doctors who go into practice in low income -- I'm sorry,  
10 in rural areas and underserved areas. A lot of those  
11 folks leave. Some of those folks stay. The -- you know,  
12 the other option is being creative about how you string  
13 together a network.

14 We are doing -- as I think we've talked about in  
15 other meetings, we're engaged in this study right now to  
16 look at our telehealth experience, because we think, for  
17 certain kinds of health care, telehealth is a viable  
18 option. It gives a second options for some people. It  
19 brings providers where there are no providers. It's  
20 particularly effective at increasing participation in  
21 behavioral health services, that -- those kinds of  
22 technological developments may allow us to put together  
23 networks in areas where we have not had networks in the  
24 past.

25 Being more creative about the entities outside of

1 hospitals that we contract with is another possibility.  
2 And, you know, we've been looking at, and will continue to  
3 look at, the possibility of moving people out of high cost  
4 areas on a voluntarily basis for schedulable surgery.

5           So there -- you know, there are some tools in the  
6 toolkit. We are talking to the carriers that are doing  
7 this work in these high cost counties about using those  
8 tools and we'll continue to do that.

9           We've been talking to Covered California and DHCS  
10 about the same thing. You know, they face a number of  
11 these challenges in areas where there are minimal --  
12 there's minimal provider coverage also. And so, you know,  
13 I've said that -- I'm meeting with Dr. Logan, with Peter  
14 Lee and Will Lightbourne from Covered California and DHCS  
15 every other week now. This is one of the things that is  
16 on the agenda. Behavioral health improvement another  
17 thing on the agenda.

18           But, you know, we ultimately -- the best way of  
19 making (inaudible) California is for the three of us to  
20 team up and send a collective message.

21           COMMITTEE MEMBER TAYLOR: Well, again, I want to  
22 thank you, and the team, and Marta for all of this hard  
23 work. So reiterating that I know you're not the only ones  
24 at the bargaining table. And it makes it difficult when,  
25 you know, you're up against a brick wall. So I reiterate

1 that by July I'm hoping that our folks -- our carriers  
2 come to the table with better rates for our members. And  
3 it's imperative. These rates are just unsustainable.

4 Thank you.

5 CHAIRPERSON FECKNER: Thank you.

6 Mr. Miller.

7 COMMITTEE MEMBER MILLER: Yeah. Thank you.

8 Thank you Dr. Moulds and Ms. Green for the presentation,  
9 the fine work of the team. I just -- I have to say that  
10 it's challenging material. It's complex. It can be  
11 confusing. But your presentation has been comprehensive,  
12 concise, it's comprehensible. Great job bringing this to  
13 us in a way that we can really understand it and go  
14 forward.

15 And I encourage you to keep the heat on in the  
16 negotiations. As my colleagues have said, we still hope  
17 to see improvements for July. And most importantly, all  
18 the work you're doing and the leadership in terms of  
19 getting to some of the really the root causes, not just  
20 the negotiations over what has happened and what is the  
21 current state, but getting to the root causes of the cost  
22 drivers of health care service and delivery and ability to  
23 have improvements on accessibility, equality, and  
24 particularly the pharmaceutical emphasis. I've talked  
25 before about my long-term vision of a world without PBMs,



1 but we're a long way from that. And so we've got to  
2 really continue to make progress where we can. And so  
3 again great job from the team.

4 I had a question -- kind of two questions. You  
5 had mentioned, Ms. Green, that we're not expecting to see  
6 the kind of COVID impact in terms of dollars, but we've  
7 still got tens of millions of people who are not  
8 vaccinated and many of whom do not intend to be vaccinated  
9 even within the health care industry. And it seems like  
10 that would be a factor that would generate ongoing concern  
11 and cost.

12 And also, last year, we basically had almost no  
13 flu season because of all the mitigation and all the  
14 precautions we took because of COVID. And with the mask  
15 mandates, and social distancing, and everything being  
16 somewhat reduced, and with again a lot of people  
17 noncompliant, even when they were in, do you see that as  
18 a -- as something that we still -- the jury is out whether  
19 we'll have costs next year as that all comes into play  
20 again?

21 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION  
22 CHIEF GREEN: Thank you, Mr. Miller. I -- it's always an  
23 inexact science predicting the future. However, you know,  
24 we do rely on a lot of the work of the various academic  
25 institutions that are looking at that kind of prediction

1 of what's going to happen with the virus. So we look at  
2 what the University of Washington is looking at. We look  
3 at what the Johns Hopkins University is looking at. We  
4 actually have our own in-house epidemiologist that's  
5 helping us think through what the viral patterns are  
6 likely to do, and then the subsequent health care costs.

7           And so even if we do see hot spots relative to  
8 low vaccination rates in each county, which, you know, I  
9 can talk at great length about vaccination rates, given my  
10 temporary assignment this year. You know, we just don't  
11 see it rising to the level that we saw over the winter.  
12 And even then, the COVID-related costs that we saw last  
13 winter when we had no vaccine for the CalPERS book of  
14 business was relatively low.

15           So now that we have a high percentage of the  
16 eligible Californians already vaccinated, even with  
17 vaccine break-through, at least from a fund perspective,  
18 we're relatively well protected. You know, we  
19 certainly -- from a health care perspective, and the  
20 health of our membership perspective, we still want our  
21 members to take all of the important precautions, and  
22 distance, and mask, and do all the things that they should  
23 be doing appropriately, and get the vaccine, if they  
24 haven't already been vaccinated.

25           But from a fun perspective, based on kind of what

1 we think the virus is going to do, it does not look like  
2 we're going to experience significant health care costs as  
3 a result of COVID.

4 COMMITTEE MEMBER MILLER: Yeah. And you kind of  
5 touched on my next question already a little bit in terms  
6 of, you know, the non-vaccinated, kind of the  
7 non-compliance factor there isn't really -- it doesn't  
8 seem to really be evenly distributed throughout the state.  
9 It seems like there are areas with much higher levels of  
10 unvaccinated people. And it seems like something that  
11 could have a differential effect, depending on what plan  
12 you're in and what part of the state you're in.

13 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION  
14 CHIEF GREEN: There are certainly regional differences,  
15 which, you know, there's great data on the California  
16 Department Public Health website on the regional  
17 differences in vaccination rates. There's also  
18 differences in vaccination rates by socioeconomic class  
19 and even by zip code, right? There's just so much  
20 interesting data about variation in vaccination rates.

21 So, yes, as we move forward in the pandemic, if  
22 we are to see outbreaks, there's likely going to be  
23 differences in where they occur. But again, as we look at  
24 it as a whole portfolio and as a whole fund, kind of in  
25 the global way, it still is not going to rise to the level

1 to where it's going to be of a major or cost driver or  
2 major cost factor for us as a fund.

3 COMMITTEE MEMBER MILLER: Yeah. And then my  
4 final question. Next year is probably too soon to be  
5 thinking about, but how is the medical community thinking  
6 about the kind of longer term implications of COVID,  
7 because there seem to be indications that there -- a lot  
8 of patients are having or may have longer term  
9 complications that aren't really as apparent right away in  
10 terms of a long-term implication for costs associated with  
11 people who have been infected and have come down with it.

12 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION  
13 CHIEF GREEN: Yeah. I think that's a really interesting  
14 question. I think there's a lot of unanswered questions  
15 about what the long-term impacts are. I always think  
16 about kind of what our colleagues in Europe think about as  
17 a bellwether, because, you know, many of those health  
18 systems are nationalized, so the governments have to think  
19 about it as, you know, kind of their long-term budgets.  
20 And many of them are thinking about it in the context of  
21 long -- of health care over the long term, like what is it  
22 going to mean for long-term kidney disease, and what is it  
23 going to mean for long-term -- other long-term health care  
24 issues.

25 And so there's just a lot we don't know and it's

1 something that we'll continue to monitor over time, but it  
2 will be very, very interesting. Dr. Moulds, do you want  
3 to add anything there?

4 CHIEF HEALTH DIRECTOR MOULDS: I was just going  
5 to add, because I'm not the right kind doctor to really be  
6 answering this question, that Dr. Logan has been tracking  
7 this very closely. And it will be a good subject for her  
8 to spend a little bit of time on when she gives a COVID  
9 update. Our COVID updates will migrate to different kinds  
10 of updates hopefully, at some point.

11 But this is -- you know, this is one I know that  
12 she's been watching carefully. The -- you know, it's an  
13 evolving -- it's an evolving area the question about  
14 long-term COVID and what it means for people who have  
15 symptoms after they had COVID is going to be something  
16 that we're going to want to watch and I know something  
17 that she's been tracking. So we'll have her say a little  
18 bit more at an upcoming Board meeting.

19 COMMITTEE MEMBER MILLER: Great. Well, thank you  
20 all and thanks to the entire team. Great work.

21 CHAIRPERSON FECKNER: Thank you.

22 Mr. Jones.

23 COMMITTEE MEMBER JONES: Thank you, Mr. Chair.  
24 Ms. Green and staff, I just want to echo my colleagues and  
25 thank you for taking such a large amount of complex data

1 and presenting it in an easy-to-follow format, so it  
2 really is -- applaud you for that.

3           Also, I want to thank you for your continued --  
4 and staff's continued effort to negotiate with our  
5 carriers, where, I believe and I'm sure that others  
6 support that, that we are trending in the right direction,  
7 but there's still work to be done. So I know you guys are  
8 working hard to get those rates to more reasonable levels.

9           Also, I want to applaud you on recognizing that  
10 looking at the information that there's some new  
11 enhancements that you negotiated in some of these  
12 packages, that -- such as nutritional counseling, and  
13 non-emergency medical transportation, and post-discharge  
14 meals, which are all beneficial to our members. So thank  
15 you for negotiating those.

16           And also, thank you for the almost on-time  
17 updates to our stakeholders. I mean, I think you crossed  
18 the Rubicon, as they said that they're getting this  
19 information almost at the same time as we're getting it.  
20 So I know they're very pleased with being kept up to date  
21 on getting this information in a very timely manner.

22           And I do have a question. I looked at some of  
23 the data. I was looking at Kaiser, for example. And I  
24 looked at -- compared to HMO, I looked at in-state versus  
25 out of state, and the out-of-state rates were higher than

1 the in-state for the HMO. Then I looked at the category  
2 that older members in Medicare like myself it's just the  
3 opposite, where the rates for the out-of-state was less  
4 than the Senior Advantage Program in-state. So why is  
5 this -- why is this different?

6 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION

7 CHIEF GREEN: It's a really good question. So for the  
8 basic -- on the basic side for Kaiser, a lot of times in  
9 various parts of the country, they rely on a blend  
10 between -- which you're used to in California, which is  
11 they're fully integrated and then some contracted access.  
12 And so you can end up with a little bit higher costs in  
13 the basic program. And so that's why you can see the  
14 out-of-state Basic ends up being a little bit higher cost  
15 than the in-state Basic, because in California it's a  
16 really well-established program and integrated. And not  
17 all places in the country, the out-of-state is as  
18 integrated as it is in California, so that's the  
19 difference there.

20 On the Medicare side, I would have to look a  
21 little bit more into it, but I suspect the opposite is  
22 true, because in the Medicare Program, as you know, the  
23 reimbursement rate is the Medicare reimbursement rate, and  
24 so you don't have those distinctions of the fully  
25 integrated versus the not integrated, because if you take

1 the Medicare rate, you take the Medicare rate. And so I  
2 suspect it has less to do with the nature of Kaiser's  
3 model and more to do with just some other states maybe  
4 just slightly cheaper. But I can look into the Medicare  
5 differential, but I'm pretty confident in the Basic  
6 differential.

7 COMMITTEE MEMBER JONES: Okay. Thank you for  
8 that explanation. Thank you. Thank you, Mr. Chair.

9 CHAIRPERSON FECKNER: Thank you.

10 Ms. Olivares.

11 BOARD MEMBER OLIVARES: Thank you, Mr. Chair. I  
12 want to thank the team for doing such a great job. It's a  
13 very thorough coverage of premiums. I think I had a  
14 similar question last year and this is going to be about  
15 the quarterly profits. So despite COVID, we've seen a  
16 marked increase in quarterly profits. Kaiser posted \$2  
17 billion in quarterly profit for Q1 2021. Anthem posted up  
18 a \$1.7 billion surplus for the Q1 2021. UnitedHealth  
19 Group had a \$4.9 billion profit for Q1 2021.

20 And so as I look at -- there's a website Kaiser  
21 Family Foundation and you can look at loss rates and you  
22 can see that average medical loss rates are actually down,  
23 profits are up, average gross margins per member are up.  
24 So as we see premiums rise, there is a very strong  
25 correlation with health insurers profits rising. I want



1 to make sure that our members are not paying for these  
2 profit increases, that they're truly costs that must be  
3 borne. How do we discern that?

4 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION

5 CHIEF GREEN: So that's why we flex fund honestly, so why  
6 we've constructed the program the way in which we've  
7 constructed it. So what we pay the carriers on a per  
8 member per month basis for their administrative fees,  
9 which includes profits, right? It's what it -- what the  
10 fees to operate including their profit --

11 BOARD MEMBER OLIVARES: Um-hmm.

12 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION

13 CHIEF GREEN: -- is static over the term of the contract.  
14 And then the carriers act as pass-through for capitation.  
15 I'm going to set Kaiser aside for just a minute. We'll  
16 talk about Kaiser separately, but everybody but Kaiser.  
17 So you've got the set per member per month payment, which  
18 is your administrative services fee. Then the carriers  
19 act as a pass-through for the capitated payments. It's  
20 directly to the providers, so whatever their --

21 BOARD MEMBER OLIVARES: Um-hmm.

22 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION

23 CHIEF GREEN: -- capitated arrangements are, and then  
24 CalPERS pays the fee-for-service claims directly. So  
25 that's why when we set the 2021 rates, we predicted a

1 little bit more fee-for-service savings, so CalPERS  
2 retained those profits or predicted those profits for the  
3 2021 plan year.

4           Now, we predicted a little bit high. We thought  
5 we would have more profit in our Health Care Fund accounts  
6 than we are seeing in clients. More claims are coming in,  
7 because we pay those fee-for-service claims directly. But  
8 what we pay the carriers on an administrative services fee  
9 in our flex-funded arrangements doesn't change. So  
10 they -- again, setting Kaiser side, they cannot profit  
11 anymore off of CalPERS' book of business than whatever  
12 they negotiate in the five-year contract, the beginning of  
13 the flex-funded term, because again they're just a  
14 pass-through for the capitated --

15           BOARD MEMBER OLIVARES: Um-hmm.

16           HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION  
17 CHIEF GREEN: -- payment arrangements and we're paying the  
18 fee-for-services amounts directly.

19           Kaiser one of the things, you'll notice is that  
20 what we're seeing with them is this -- one of the lowest  
21 increases in the entire book of business. And we have  
22 been working very closely with Kaiser to look at not only  
23 its total financial position, our total financial position  
24 within their book of business, but also the utilization of  
25 our membership and our own claims data, which is why we

1 gather all of the claims encounter data to understand how  
2 much we are using -- how much health care we are using  
3 relative to their book of -- book of business or their  
4 total, so that we know that we're getting a really good  
5 deal or a very good deal from Kaiser.

6           So on the flex-funded sided, they actually can't  
7 increase profits, because it's negotiated at the beginning  
8 of the five-year term. And on Kaiser, we -- because it's  
9 fully insured, we have to take a slightly differ tack and  
10 actually dig into their finances and dig into specifically  
11 the finances relative to our membership and our  
12 utilization. So that's kind of the two ways in which  
13 we're really monitoring the spend on behalf of our  
14 membership.

15           BOARD MEMBER OLIVARES: And when setting up the  
16 administrative fee, and I know that does include a bit of  
17 profit, how are we determining what's a reasonable amount  
18 of profit?

19           HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION  
20 CHIEF GREEN: Well, we don't delineate profit within the  
21 administrative services fees, so we look at the fee itself  
22 on per member per month basis and we just aggressively  
23 negotiate that fee and pit the carriers essentially  
24 against each other to ensure that we get the lowest  
25 administrative services fee that we can get from our

1 carriers, because we really want to ensure that it's the  
2 leanest product design as possible.

3           So we don't say that of the per member per month  
4 that, you know, \$0.50 is profit, but what we say is that  
5 you're going to come in as low as humanly possible.

6           BOARD MEMBER OLIVARES: So if profits are rising  
7 across all the carriers at almost unforeseen levels, how  
8 does that competitive model work?

9           HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION

10 CHIEF GREEN: Well, a lot of times what's happening with  
11 profits, and one of the reasons that you're seeing in some  
12 of the other market segments some rate changes that are  
13 different is that the fee-for-service savings that CalPERS  
14 is retaining in our fully insured product, the carrier  
15 would be retaining as profit.

16           So that's why I'm saying CalPERS is actually  
17 who's retaining the profit, in this case, as opposed to  
18 the carrier. Because in a traditional fully insured  
19 product, what's happening is let's say you negotiate a  
20 \$700 a month premium for a product. And you say, okay,  
21 I'm predicting that, you know, 300 is, you know, for  
22 capitation, and 300 is for fee-for-service, and a hundred  
23 is for -- is that rate, so you've somehow broken it down.  
24 If you've predicted that \$300 is for fee-for-service, but  
25 because of whatever happened, and maybe in this case it's

1 COVID, only \$150 was actually spent on average per member  
2 per month for fee-for-service, then that is withheld by  
3 the carrier's profit. And that actually counts against  
4 their medical loss ratio, because they didn't actually  
5 spend it. And then in the individual and small group  
6 market, as you alluded to, they actually owe that back to  
7 their purchasers as rebates, because they have to spend  
8 it.

9           But because we flex-fund and we don't actually  
10 give the carriers that money, we retain it and we pay the  
11 fee-for-service claims directly, they actually can't float  
12 their profits up and down, because CalPERS retains that  
13 money. And so that's why it's static. Whatever they can  
14 make on us, doesn't change. So globally in the market, in  
15 the fully insured market, it can go up and down, and  
16 that's why you see these big swings in the quarterly  
17 profits, because the patterns of health care change, but  
18 that's because they can take in the profits associated  
19 with lower utilization, whereas CalPERS gets to keep those  
20 profits associated with lower utilization, as opposed to  
21 the carrier, because of the nature of the products that  
22 we've designed.

23           BOARD MEMBER OLIVARES: I understand how that  
24 model works. I guess where I'm a little bit confused or  
25 I'd like more information is really understanding how we

1 go about verifying the fee-for-service payments and what  
2 goes into that, because there might be additional costs in  
3 that, that we --

4 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION

5 CHIEF GREEN: To the providers? The fee-for-service  
6 payments to the providers?

7 BOARD MEMBER OLIVARES: Um-hmm.

8 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION

9 CHIEF GREEN: Oh, they bill us directly. The providers  
10 bill us directly.

11 BOARD MEMBER OLIVARES: Right. No, I understand  
12 that. We'll talk offline. There's -- I would like to get  
13 some additional information.

14 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION

15 CHIEF GREEN: Okay. I'd be more than happy to.

16 BOARD MEMBER OLIVARES: Thank you.

17 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION

18 CHIEF GREEN: Yeah.

19 COMMITTEE MEMBER JONES: Did Rob go offline?

20 VICE CHAIRPERSON RUBALCAVA: I don't see him.

21 COMMITTEE MEMBER TAYLOR: It's all you, Ramon.

22 COMMITTEE MEMBER JONES: It's all you, Ramon.

23 VICE CHAIRPERSON RUBALCAVA: Oh. I think --

24 MEETING MODERATOR: Sorry. He's coming online  
25 right now.

1           VICE CHAIRPERSON RUBALCAVA: Okay. Yes, because  
2 we have one more speak -- one person -- Board member  
3 wanted to speak, I think.

4           (Thereupon a brief recess was taken.)

5           CHAIRPERSON FECKNER: Very good. Well, it booted  
6 me off, so I'm going to have to go back on the phone. I  
7 don't have anybody else on my list from the Board --

8           VICE CHAIRPERSON RUBALCAVA: I think Karen --

9           CHAIRPERSON FECKNER: -- but I know we have --

10          VICE CHAIRPERSON RUBALCAVA: I think Karen Greene  
11 still wanted to speak, is that correct?

12          CHAIRPERSON FECKNER: Okay. Karen Greene-Ross,  
13 please, while I try and rehook.

14          ACTING COMMITTEE MEMBER GREENE-ROSS: Sure. And  
15 I just had a quick question, which I do not expect Don or  
16 Marta to have the answer to, but just something we should  
17 think about going forward. There's always another  
18 variable on -- that's likely to impact future health care  
19 costs, particularly for Medicare, was the recent approval,  
20 controversial as it was, for the FDA to approve the new  
21 drug -- first drug to target Alzheimer's disease, which  
22 I'm sure a significant portion of our beneficiaries  
23 unfortunately have to worry about, or deal with, or their  
24 family members.

25                 And it's a potential cost disruptor, because of

1 the pressure of the expensive tests people -- advocates  
2 may be pressuring purchasers for the cost -- to cover the  
3 cost to assess it. So I just think -- I was just going  
4 to, you know, add that to sort of David Miller's questions  
5 about long-term effects of COVID and other things we're  
6 looking at going forward. I think we probably should have  
7 to unfortunately look at the impacts of that recent  
8 decision and what that might mean for our costs going  
9 forward.

10 So I was just -- I wanted to just mention that,  
11 because when David brought his questions up, I was  
12 thinking about the recent article I've just read about  
13 that approval.

14 CHIEF HEALTH DIRECTOR MOULDS: Yeah, it's a  
15 good -- it's a good -- it's great point -- it's a great  
16 point. As you know, there are -- there are sort of mixed  
17 reviews as to efficacy. It's not cheap. And, you know,  
18 we will presumably know more now that it's approved in  
19 the -- as we watch experience, but we'll also need to  
20 watch it as both a potential cost driver or as a potential  
21 cost saver if it's effective and delays the symptoms of  
22 dementia.

23 ACTING COMMITTEE MEMBER GREENE-ROSS: Great. And  
24 then just again, thank you for -- everybody for all the  
25 hard work that we know goes into all this work with the



1 rates and trying to keep the cost down for everybody. So  
2 thank you.

3 CHAIRPERSON FECKNER: Thank you. I don't have  
4 anything left in my chat room. Mr. Rubalcava, is there  
5 anybody after Ms. Greene-Ross?

6 VICE CHAIRPERSON RUBALCAVA: That's all I have.

7 CHAIRPERSON FECKNER: Very good. Thank you.  
8 Now, I know we have a number of callers from the public.

9 Mr. Fox, please.

10 STAKEHOLDER RELATIONS CHIEF FOX: Yes, Mr. Chair.  
11 We have ten callers on the line. The first of which will  
12 be Lisa Bocast from SEIU.

13 MS. BOCAST: Can you hear me? Hello. Can you  
14 hear me?

15 CHAIRPERSON FECKNER: Yes, we can hear you.

16 MS. BOCAST: Okay. Great my question is -- I'm  
17 Lisa Bocast. I'm from SEIU Local 1000. I live in Shasta  
18 County.

19 There was mention in the past about a new option  
20 for Shasta in Lassen County is I believe it was Blue  
21 Shield EPO. Is that still an option for us this coming --  
22 upcoming and when will we have information before open  
23 enrollment on cost and networking, so we can look -- make  
24 an educated choice on what's going to be the best plan for  
25 our members?

1 CHAIRPERSON FECKNER: Ms. Green.

2 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION

3 CHIEF GREEN: Yes. So that's part of the Blue Shield  
4 Access+ expansion. So if you look at the Access+ --

5 MS. BOCAST: Oh, it is. Okay.

6 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION

7 CHIEF GREEN: Yes.

8 MS. BOCAST: Okay. Perfect. Thank you. That  
9 was my only question.

10 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION

11 CHIEF GREEN: You're welcome.

12 CHAIRPERSON FECKNER: Very good. Thank you.

13 Mr. Fox.

14 CHIEF HEALTH DIRECTOR MOULDS: To answer the  
15 question about when you'll have costs, we'll have -- so  
16 regional rates should be in the -- for rates -- the  
17 rates --

18 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION

19 CHIEF GREEN: Preliminary regionals are in -- are in the  
20 rate sheet for June. Final regionals will be in the rate  
21 sheets for July. But preliminaries are in rates sheets  
22 for June.

23 CHIEF HEALTH DIRECTOR MOULDS: That will give you  
24 price information.

25 CHAIRPERSON FECKNER: Thank you.

1 Mr. Fox.

2 STAKEHOLDER RELATIONS CHIEF FOX: Yes, Mr. Chair.  
3 We have Joanne Hollender from RPEA.

4 MS. HOLLENDER: Thank you. I want to, first of  
5 all, thank the Board and the Committee members for your  
6 work and dedication. And, of course, the CalPERS health  
7 staff for doing all the work that you're doing. I do have  
8 a few comments about the PPO plans. And I am alarmed with  
9 the amount of increase that are in the PPOs compared to  
10 the other plans that are PPO and HMO. It is very  
11 disturbing that, you know, we have over a 10 percent  
12 increase. But one of the things we have to keep in mind  
13 the high quality affordable health care, and that's one of  
14 my goals. I wanted to make a couple comments about the  
15 PPO basic plan.

16 If you recall, and I know many of you are new  
17 members on the Board and the Committee. And going back to  
18 Kathleen Donneson, excess reserve funds have been used to  
19 the double digit percentage increases to subsidize the  
20 PERSCare Basic plan. And so it has been continually  
21 propped up for years. And I know this is to be true,  
22 since I follow all this along. But also, it seems the --  
23 I'm losing my train of thought, I apologize.

24 Also, the rates are coming -- if you were in  
25 PERSCare, you didn't change to a Platinum, you would be

1 getting a reduction of \$168.74 a month, which is -- does  
2 not adjust for regional pricing, which is always higher.  
3 And the folks in the PERS Choice plan would be getting --  
4 paying \$93.90 additional. And the folks in PERS Select,  
5 which is still an 80/20 not a 90/10, would be paying  
6 \$120.88 a month more.

7           And it seems to me that perhaps there could be  
8 some adjustment so that you're not chasing all your PERS  
9 Choice folks away. It's a major hit to them. I know  
10 there's five and a half times more people in PERS Choice  
11 than PERSCare, but it is a significant change for those  
12 folks to go into this Platinum plan.

13           And with the regional pricing, it's probably  
14 going to be astronomical. So I do want to make that  
15 comment. And some of the funds that were excess reserve  
16 funds, I might add. Some of that money should have gone  
17 back to the Medicare plans -- PPO Medicare plans, and very  
18 little went. I think maybe I understood from one person  
19 it was \$19,000. Very little compared to the Basic PPO  
20 PERSCare plans.

21           And then I wanted to mention the Medicare  
22 Supplemental plans. There's very little difference  
23 between a PERS Choice design plan and the PERSCare, which  
24 is now going to be combined into the Platinum plan.  
25 There's very, very little difference in the benefits. And

1 yet, why would I be wanting to pay \$36.07 a month more for  
2 the Platinum Plan for my PERS Choice plan -- my Medicare,  
3 that is, plan. I know you have three other Medicare plans  
4 you're adding, which I commend the staff, but I don't  
5 really want to chase away our members. And it looks look  
6 there was an 8.1 percent snapback too. So if you look at  
7 the PERSCare folks they'd only be paying \$4.79 more than  
8 they're paying now.

9           So if you really look at it, I think things  
10 should be evened out more along the plans, so that you're  
11 not chasing folks away, that you're keeping the members  
12 there. I know you have fee-for-service and all that. And  
13 I find it hard to believe that PERS Choice and PERS Select  
14 just have so many more claims than the PERSCare plan. I  
15 just don't understand that, other than maybe the number of  
16 people in it.

17           But it does seem significantly higher than I've  
18 seen. You know, 15.2 percent premium change for PERS  
19 Choice. It would be 22.92 for the Basic plan and 15.71  
20 for the PERS Choice Medicare, and 9.66 for the PERS  
21 Select. And I know you're doing your best, but it seems  
22 like you could do more. I think more could be done to  
23 make this work better.

24           I don't really want to change my plan, but I'm  
25 going to look around and I may look around outside of

1 PERSCare, or PERS Choice, and PERS whatever I have right  
2 now. I think it's Choice. Sorry. But I think this is  
3 very important to keep that in mind when you look for your  
4 self-funded plan. It's not competitive with the other  
5 plans out there. And I know it's a tough challenge for  
6 you, but we really should do better.

7 So thank you again for your time. I appreciate  
8 it. And I hope you can take this into consideration in  
9 your rate development.

10 Thank you.

11 CHAIRPERSON FECKNER: Thank you.

12 Mr. Fox.

13 STAKEHOLDER RELATIONS CHIEF FOX: Mr. Chair, next  
14 we have Alexandra Tkacheff.

15 MS. TKACHEFF: Hi, name is Alexandra. Can you  
16 hear me?

17 CHAIRPERSON FECKNER: We can.

18 MS. TKACHEFF: Excellent. Thank you so much.

19 Pleasure to speak to the Board today. I am  
20 calling on behalf of SEIU and then also a member of  
21 CalPERS. I work at the Department of Education. I  
22 currently went two years ago -- I'm calling not primarily  
23 because I have a question, but to give you some background  
24 and statement on how health care impacts your members.  
25 About two years ago -- I'm 33 and about two years ago, I

1 was diagnosed with cancer. And then it proceeded to  
2 evolve into a Stage 4 cancer situation. And I'm in the  
3 process of fighting it and actually recovering from that.  
4 So I'm very grateful to have the health care that I have.  
5 In the process, I went from a normal healthy 33-year old  
6 to somebody who's dealing with chronic, potentially  
7 life-long condition.

8           And in that process, I learned what the  
9 difference was between somebody who was using a deductible  
10 on an annual basis, and someone who had generally good  
11 health to someone with a chronic condition. As far as  
12 impact goes, the changes to health care plans -- I use a  
13 PPO and not an HMO, because I'm using a lot of specialized  
14 treatment.

15           So in that way access has actually been really  
16 helpful. But on the flip side, I'm spending 10 to 20  
17 percent of my income on -- gross income, not net, on not  
18 only costs not provided by -- on all costs that are  
19 related to insurance, but not covered. So let's  
20 deductibles, doctors visits, things of that nature.

21           In addition to that, there's costs outside of  
22 insurance that I've had to provide fund raisers for. And  
23 in addition to that, I've had costs that were run through  
24 preapproval, but were not pre-authorized, and I had like  
25 bills up to \$5,800 show up on my door step that I had to

1 go through an appeals process for over a year.

2           Someone with my skills and abilities to navigate  
3 the medical system -- I'm a certified project manager and  
4 I also deal with student data. I have been able to  
5 navigate it. But dealing with treatment plus having to  
6 navigate a difficult health system, plus having costs on  
7 top of that, I would encourage the Board to really  
8 consider the adjustments in the rates for their members.

9           For example, what is now going to be called PERS  
10 Gold is not accepted through several providers within the  
11 Sacramento area. And that would be a significant cost  
12 reduction for me on an annual basis, if I could get care  
13 through that insurance plan versus what is now going to be  
14 called the PERS Platinum, though that I can see that there  
15 is effort to change and increase coverage and cost -- and  
16 reduce costs that way.

17           The overall general impact that I wanted to kind  
18 of state here is that you have a lot of chronic members,  
19 not only members who are working, but members who are also  
20 in retirement, who are participating and they're maxing  
21 out their deductibles on an annual basis, because they  
22 have to deal with the services on a regular basis.

23           So the more effort that we can make to reduce the  
24 monthly rate or potentially deductible side is very  
25 helpful. One of the things I found out is that by maxing



1 out the deductible, the monthly rate doesn't necessarily,  
2 let's say, matter too much. So let's say I have 90/10  
3 coverage. While my rate is a bit higher, at the end of  
4 the day, if I am maxing out my deductible, my cost at the  
5 end of the day out of pocket is close to the same. It's  
6 more about where do I want to pay it, not so much that the  
7 cost is significantly less or significantly less impact.

8           So I'm hoping that some of that information can  
9 go into consideration as you're looking at your rates, is  
10 that when you're looking at people who are high risk, and  
11 the reason why they're in certain buckets, primarily it's  
12 because on a monthly basis it's affordable and if they had  
13 to increase their costs, it would take away from their  
14 resources on a regular ongoing basis.

15           And that ongoing kind of burden is actually the  
16 biggest burden for someone in my condition or someone,  
17 let's say, diabetes, or someone with Lupus, or someone who  
18 has -- you know, working at an eight-hour job and has --  
19 they're in good -- they're in good stable condition, but  
20 they're having to deal with health services that are more  
21 costly than let's say somebody who's just going in for a  
22 regular checkup.

23           So I just wanted to be a voice on this call for  
24 anybody who is dealing with those situations, that that be  
25 considered, and that there are probably more people that

1 are working on staff. I don't have obviously the  
2 statistics, but there's probably more people on staff and  
3 employees that are dealing with conditions like this, that  
4 have not worked out.

5 CHAIRPERSON FECKNER: Your time has expired,  
6 ma'am.

7 MS. TKACHEFF: Thank you so much.

8 CHAIRPERSON FECKNER: Thank you.

9 Mr. Fox.

10 STAKEHOLDER RELATIONS CHIEF FOX: Mr. Chair, next  
11 we have Mr. Tim Behrens from CSR.

12 MR. BEHRENS: Hello.

13 CHAIRPERSON FECKNER: Yes, sir.

14 MR. BEHRENS: Yeah. Good afternoon, Chairman  
15 Feckner. Thank you for the opportunity to comment. CSR  
16 acknowledges the many challenges assessing the true costs  
17 of health care and negotiating reasonable rates during the  
18 COVID pandemic. We really appreciate the efforts of the  
19 CalPERS health team, especially with the expansion of  
20 plans geographically in the state and the offering of some  
21 new plans.

22 However, we believe there is strong evidence that  
23 rate increases should be minimal, remain roughly the same  
24 or even be lowered in some cases for 2022. I really like  
25 what Dr. Moulds said -- his comments on creating more

1 competition. Let's use CalPERS' purchasing power as  
2 leverage with health care providers, because some of them  
3 don't seem to understand what creating a partnership  
4 means.

5 And with that, CSR's Chair of Health Benefits  
6 Committee, Larry Woodson will present -- present more  
7 detailed support for our position.

8 Thank you.

9 CHAIRPERSON FECKNER: Thank you.

10 Mr. Fox, please.

11 STAKEHOLDER RELATIONS CHIEF FOX: Yes, Mr. Chair.

12 Next, we have Mr. Larry Woodson from CSR.

13 MR. WOODSON: Good afternoon. Larry Woodson,  
14 CSR. Can you hear me okay?

15 CHAIRPERSON FECKNER: I hear you just fine.

16 MR. WOODSON: Great. Well, I'd first like to  
17 thank you, Mr. Feckner, for the opportunity to comment and  
18 for your initial comments, as well as some of the other  
19 Board members' comments. And I'd also like to thank Dr.  
20 Moulds and Marta for a really good presentation to us or  
21 the special -- her initial special stakeholders briefing,  
22 and then we are allowed some time to caucus among  
23 ourselves as stakeholders. Appreciate that very much.

24 First, I think the Medicare rates that are  
25 presented here are reasonable overall. Probably for one

1 reason the Medicare Advantage plans are highly profitable  
2 to carriers, but the HMO rates is another matter. They're  
3 much higher than my research into the latest cost data for  
4 2020 and '21 nationally and in California would justify.

5 I'm going to be with the general landscape of  
6 health care costs. California carriers achieved massive  
7 profits for much of 2020 when elective procedures were  
8 postponed due to COVID. And that carried over in 2021  
9 with a spike in COVID in January through March.

10 As Dr. Moulds pointed out, utilization has  
11 increased, but it's increased slowly from my sources, and  
12 not to the same levels, according to health articles I've  
13 found.

14 Federal subsidies to hospitals due to COVID costs  
15 help offset high hospital costs. And a well respected  
16 actuary, Dave Dillon, who's a Fellow in the American  
17 Society of Actuaries, he states that insurance rates  
18 should stay about the same in 2022. He estimates that the  
19 highest increases -- and, you know, he acknowledges it  
20 would vary, but the highest increase should be no higher  
21 than four percent and about a four percent decrease on the  
22 other side to balance out to around zero.

23 Well, UnitedHealthcare is double that with over  
24 eight percent and also the average increase for HMOs is  
25 4.83 percent, which is way too high. That's higher than

1 last year's percent increase of 4.44.

2           Looking at the financial landscape of the  
3 carriers in CalPERS universe of plans. And I know I'm  
4 going to be redundant here. I appreciate Stacie Olivares  
5 comments. I'm going to begin UnitedHealth. In the just  
6 released Fortune 500 list, UnitedHealth Group jumped from  
7 7th to 5th this year. Their revenue increased 6.2 percent  
8 over last year. And in spite of costs of covering COVID  
9 patients, UnitedHealth Group profits jumped 11.3 percent,  
10 or 15.4 billion, in 2020. Now, this was due largely to  
11 profits from Optum and their Medicare Advantage plans.

12           I also found that they're doing quite well in  
13 2021 with a whopping first quarter profit jump of 44  
14 percent. So they don't need our eight percent -- an eight  
15 percent increase with these kind of profits. And I  
16 understand Marta's explanation, but the big picture is  
17 they're doing well.

18           You know, Blue Shield of California, they  
19 reported profits increase of 3.1 percent over 2019.  
20 Kaiser Permanente remained well in the black in spite of  
21 COVID in 2020, with a net income or profit of 6.4 billion.  
22 They continue to do well in '21 with a first quarter  
23 profit of two billion.

24           As CalPERS -- I think it was Ms. Olivares pointed  
25 out during the meeting last year, Kaiser has an enormous

1 reserve fund for a nonprofit. Lastly, Anthem Blue Cross  
2 moved up to 23rd on the Fortune 500 with 16.9 percent  
3 increase in revenues.

4 To address some specific preliminary rate  
5 increases, I'll start with PPO self-funded. I'm glad to  
6 see that the rates for Platinum and Gold did come in  
7 slightly less than the November projections. And I  
8 understand the concerns of some of the contract employees  
9 who don't have as good a plan as the State retirees.

10 But the rates for UnitedHealthcare at 8.9 percent  
11 are unacceptably high. While the drug costs may have  
12 driven them up some, it's the 6.9 percent increase in  
13 medical costs that's the main driver. And, you know, that  
14 really is suspect, given all the profits they made during  
15 the year, because of delayed elective procedures.

16 Anthem HMO Select 7.72 percent really raises a  
17 red flag. Again, their main driver is medical costs and  
18 that seems to be across the Board. Medical costs are the  
19 main driver, not drug cost increases. And I don't think  
20 that is correct. I think CalPERS needs to really examine  
21 that closely.

22 And finally, I hope the Board and I believe they  
23 will or have said so in their comments, but I recognize  
24 that these are truly preliminary rates and that the staff  
25 goes back and in July we see some more reasonable final

1 rates on those that have done -- have such excessive  
2 increases.

3 So thank you for your time.

4 CHAIRPERSON FECKNER: Thank you.

5 Mr. Fox.

6 STAKEHOLDER RELATIONS CHIEF FOX: Yes, Mr. Chair.  
7 The next person is Mr. Jared Ramey from SEIU.

8 MR. RAMEY: Thank you. Hello. My name is Jared  
9 Ramey. I live in Shasta County. I am a State employee.  
10 I have the PPO system to choose from, which is not very  
11 good, because it's Anthem Blue Cross. They are a monopoly  
12 here in Northern California. They provide poor service at  
13 a high cost.

14 I have a chronic mental health condition. I am  
15 bipolar. I have severe PTSD and severe anxiety.  
16 Sometimes it puts me to the point where I cannot work.  
17 During COVID, I had three hospital -- three emergency room  
18 visits, plus a stay in mental health.

19 I have probably bills that total between 8 to 10  
20 thousand dollars from last year. My biggest problem is  
21 the coinsurance that we have to pay with the PPO. And I  
22 was wondering if that would be going away with the new  
23 system.

24 I spend probably between 250 to 300 dollars a  
25 month on health care costs that include -- that is not --

1 that does not go towards my coinsurance. Those are  
2 doctors visits, therapist visits, and my out-of-pocket  
3 medical expenses for my medication.

4 I am also a non-straight passing LGBTQ person, so  
5 finding an LGBTQ friendly doctor in this very homophobic  
6 environment is very difficult for me. I went through over  
7 10 doctors before I found a primary care doctor that was  
8 LGBTQ friendly. And I probably called 30 to 40 doctors on  
9 the list that they said -- that Anthem provided me that  
10 said we're taking new patients. More than half of those  
11 people I called were either, one, no longer taking our  
12 insurance, or they were not taking new patients, or they  
13 were not LGBTQ friendly. That is all I have to say.  
14 Thank you for your time.

15 CHAIRPERSON FECKNER: Thank you.

16 Mr. Fox, please.

17 STAKEHOLDER RELATIONS CHIEF FOX: Mr. Chair, the  
18 next caller is Debbie Gibson from SEIU.

19 MS. GIBSON: Hi. This is Debbie. Hi. This is  
20 Debbie. Can you hear me?

21 CHAIRPERSON FECKNER: Yes, we hear you.

22 MS. GIBSON: Okay. My name is Debbie Gibson.  
23 I'm from SEIU and I actually also live in a rural area.  
24 And I was wondering -- I've noticed more and more the  
25 providers are out of network, so I was wondering what is



1 CalPERS doing to elevate the out-of-network doctors versus  
2 the network doctors.

3           So like I had a specialist for a while,  
4 endocrinologist and I go there, and, oh, we're not in your  
5 network any more, but you can still come here and just pay  
6 out of pocket, and then I therefore don't have the  
7 benefits, even though I have insurance. So I was  
8 wondering what is -- is there anything being done to  
9 evaluate that as doctors drop out of network and there's  
10 less and less for us to even choose from as a available  
11 provider.

12           CHAIRPERSON FECKNER: Anything else, ma'am?

13           MS. GIBSON: No. I would just like to make sure  
14 that that's evaluated, because I am in a PPO as well.  
15 There is not an HMO -- an option and I don't know what the  
16 answer is when a doctor can choose to be out of network,  
17 but then that's the only doctor that we have a choice to  
18 go to. So I'd like for that to be evaluated in then new  
19 contract.

20           Thank you.

21           CHAIRPERSON FECKNER: Thank you.

22           Mr. Fox.

23           STAKEHOLDER RELATIONS CHIEF FOX: Yes, Mr. Chair.  
24 We have Polly Coughlin a State employee.

25           MS. COUGHLIN: Hi. Yes. I am from SEIU as well.

1 My name is Polly Coghlin. I live in West Sacramento and  
2 these are my concerns.

3 In the past, I have gone to a doctor at a  
4 facility that was covered thinking that the normal  
5 wellness routine procedure was covered and I confirm with  
6 the doctor. That's one of the questions I ask whenever I  
7 go to a doctor is I want to make sure that it's covered.  
8 And I instead got a bill for \$600 for an annual mammogram.

9 When I appealed it, they denied it and CalPERS  
10 said I should call the insurance company directly and  
11 negotiate for a better price, which they did not do. So  
12 ended up paying the \$600 for a routine wellness mammogram.

13 In December of 2020, I called to ask what  
14 mammogram provider is covered. They didn't have anyone.  
15 And again, I live in Sacramento. Finally, I told them  
16 that -- I asked if I went to UC Davis would that be  
17 covered and it was covered.

18 I also damaged my foot and I went to urgent care,  
19 and again I got a bill saying that the services were not  
20 covered. When I called to find out why I was getting  
21 billed for it, they said that because it was an emergency  
22 they would cover it, but this was only after I called.

23 Last year, I switched to an HMO, I pay \$130 more  
24 a month, because I was scared that if I went to a doctor  
25 under COVID, if I ever got COVID and I had to go to an

1 emergency room and see a doctor, I would get gigantic  
2 bills that were not covered and I wouldn't be able to  
3 afford to pay. So I had PPO CalPERS Select and now I have  
4 switched to Blue Shield HMO Trio. And those are my  
5 concerns.

6 Thank you.

7 CHAIRPERSON FECKNER: Thank you.

8 Mr. Fox.

9 STAKEHOLDER RELATIONS CHIEF FOX: Yes, Mr. Chair.  
10 The next caller is J.J. Jelincic.

11 MR. JELINCIC: Hi. This is J.J. Jelincic. I'm  
12 Health Director for RPEA.

13 I want to say something you've never heard me say  
14 before during rate negotiations, the rates are too damn  
15 high. I also recognize that it is a national problem not  
16 a CalPERS problem.

17 I'm hearing a lot of static, am I -- are you  
18 hearing me?

19 CHAIRPERSON FECKNER: Yes, we can hear you.

20 MR. JELINCIC: Okay. Thank you.

21 MARA uses cost, which fees times usage to measure  
22 risk and they're trying to equalize the risk. And that  
23 works if all of the vendors have the same fees, but that's  
24 not the case here. All plans have a different fee  
25 schedule with the exception of Medicare. I had said the

1 intent was to protect the insurance companies and the  
2 score high -- and to save high cost plans. I was told I  
3 was wrong, parenthetically some times I -- something I'm  
4 used to hearing. Although, it's common for my comments to  
5 come back from others a year later.

6 But look at what's going on here. And I want to  
7 start with the basic plans, because many of our members  
8 are not Medicare eligible. If you look at the plans,  
9 Anthem Traditional gets a \$98 a month subsidy for the  
10 13,000 people in it. Blue Shield Access+, \$117 a month  
11 subsidy for the 8,000 people in it. The 560,000 people in  
12 Kaiser are going to pay an additional \$22 a month to help  
13 offset that. The people in Sharp are going to pay  
14 basically \$41 a month to help subsidize that.

15 There is a -- what -- if you look at the  
16 subsidies, it actually goes subsidize the high cost plans  
17 to save the low cost plans. When you look at PERSCare  
18 Basic, PERS -- or the PPO -- PERSCare basic is -- the  
19 25,000 people in that are going to get \$133 a month  
20 savings. To finance that, 142,000 people -- 142,000  
21 people in Choice are going to pay an extra \$94. And the  
22 110,000 people in Select are going to pay an extra 121.  
23 It's really about protecting the high cost plan.

24 On the supplemental side, quite frankly, the HMOs  
25 are too high, but they're at least reasonable. But if you

1 look at the PPOs, the 66,000 people in Care are going to  
2 pay an extra \$5. The 79,000 people in -- who were in  
3 Choice are now being moved to Platinum are going to pay 36  
4 bucks. And the 3,000 people in Select are going to pay an  
5 additional \$26 a month.

6 Part of the problem with this is that it really  
7 encourages the vendors to pay higher fees. Because of the  
8 way it's being calculated, if you increase the amount that  
9 you pay in fees, you will get a higher risk score, even  
10 though nothing else has changed, and you will get a  
11 greater subsidy. You really need to rethink how you are  
12 doing this risk adjustment.

13 For this year, it's baked in, but give some real  
14 thought to whether this is, in fact, the road you want to  
15 continue on next year. And you have previously indicated  
16 that right now you're just treating the HMOs as a group.  
17 Your plan is to treat the HMOs and the PPOs in the same  
18 risk pool. Although, we've heard today consistently that  
19 PPOs are much more expensive, because of the fact that  
20 there's greater use of specialists and greater use  
21 generally.

22 So I thank you for your time. I ask you to  
23 really rethink whether this is the route you want to go.

24 Thank you.

25 CHAIRPERSON FECKNER: Thank you. Mr. Fox.

1           STAKEHOLDER RELATIONS CHIEF FOX: Mr. Chair, the  
2 last caller is Maria Blaine a CalPERS member.

3           MS. BLAINE: Hello, everyone. Thank you for  
4 taking my call. I'm calling on behalf of -- I work for  
5 the State of California and I'm a member of SEIU. I'm  
6 calling on behalf of a member. She is unable to be here  
7 today to make the comments, but she's working as a teacher  
8 at Pelican Bay Del Norte.

9           Her insurance is a PPO. Currently, her claims  
10 from a March hospitalization are being denied as not  
11 network, not preapproved, and not an emergency. A 2 --  
12 she is facing a \$265,000 bill due to -- because Anthem is  
13 telling her it is her responsibility to pay. The member  
14 was air lifted by ambulance to the only available hospital  
15 that was taking patients during the pandemic.

16           She was also receiving intravenous pain  
17 medication and assumed that the doctor and hospital staff  
18 were representing her best interests and doing their  
19 diligence or prerequisite parts in assuring prompt  
20 payments from the insurance companies.

21           Also, this is -- so we have some -- this is not  
22 her -- the first case we hear about this and it is not the  
23 first issue that we've heard in this meeting. Please also  
24 know that the member had to take an Uber home after being  
25 discharged from the hospital from her surgery. It was a

1 325 mile for a six hour drive. There was no compensation  
2 for that. It was just an out-of-pocket expense.

3 The total monthly payments for personal -- for  
4 her person for medical insurance is too high. The member  
5 is currently doing all the work and spending countless  
6 hours coordinating the bills in order to appeal and do the  
7 medical work necessary to receive some kind of relief.

8 So we have a follow-up question is, is the -- are  
9 you tracking out-of-network costs that these members are  
10 forced to pay and are dealing with? It just amount to  
11 high level of stress and anxiety contributing to the  
12 detriment of their physical health?

13 Thank you for taking my call.

14 CHAIRPERSON FECKNER: Thank you.

15 Mr. Fox is that the last caller?

16 STAKEHOLDER RELATIONS CHIEF FOX: Yes, Mr. Chair,  
17 that was the last caller.

18 CHAIRPERSON FECKNER: Thank you.

19 Well, we heard a trend in a lot of those calls.  
20 And I will say that Mr. Moulds and Ms. Green, I did tell  
21 you that we met with SEIU a week ago and heard a lot of  
22 these concerns about the out-of-network, et cetera. I  
23 asked for back-up information with plans, et cetera, so we  
24 could pass that on to you, because we want to make sure  
25 our members are protected. We have yet to hear anything

1 in regards to that conversation. So although I heard the  
2 members today, we have heard that. We're waiting for  
3 information so that we can make sure that we can start  
4 pushing the buttons on our end.

5 With that, I have Ms. Middleton.

6 BOARD MEMBER MIDDLETON: Okay. Thank you, Mr.  
7 Chair. I want to respond a bit to the gentleman from  
8 Shasta County who spoke. I first started with the State  
9 of California in 1974. I can tell you in the 47 years  
10 that have transpired, for those of us in the LGBTQ+  
11 community our access to culturally competent health care  
12 has changed from night to day. Things have improved  
13 tremendously. But that is most particularly true in  
14 metropolitan communities and in larger communities.

15 And I know that Dr. Logan, Dr. Moulds, Ms. Green  
16 have just done exceptional work. But access to culturally  
17 competent health care across the state is something that  
18 is incredibly important. Individuals within the LGBTQ  
19 community defer and avoid accessing health care  
20 frequently, because they fear facing discrimination.

21 Most of us in my community can recount one or  
22 more instances of discriminatory or just blatantly  
23 unprofessional conduct that we have encountered in medical  
24 offices at some point in our life.

25 So everything that we can take and due to ensure



1 that we make it easier for our members who are within the  
2 LGBTQ community, particularly in rural areas, have access  
3 to culturally competent health care is something that is  
4 really important.

5 And thank you.

6 CHAIRPERSON FECKNER: Thank you.

7 Seeing no other requests to speak, Ms. Green,  
8 anything else you'd like to add?

9 HEALTH PLAN RESEARCH & ADMINISTRATION DIVISION

10 CHIEF GREEN: No, thank you. Thank you, Chairman Feckner.

11 CHAIRPERSON FECKNER: Great. Well, again, thank  
12 you for a great presentation. And thank your entire team.

13 Mr. Moulds, anything else on this agenda item?

14 CHIEF HEALTH DIRECTOR MOULDS: Nothing from me.  
15 Thank you, Mr. Chair.

16 CHAIRPERSON FECKNER: All right. The next agenda  
17 item is the Summary of Committee Direction. Mr. Moulds.

18 CHIEF HEALTH DIRECTOR MOULDS: I have two items.  
19 The first is to ask Dr. Logan to speak about long COVID  
20 and longer term effects of COVID in a future COVID update  
21 to the Board. And the other one is to continue monitoring  
22 Aduhelm, which is the new Alzheimer's disease --  
23 Alzheimer's drug that was just approved by the FDA, both  
24 for increased new evidence about -- to shed more light on  
25 efficacy as well as on the cost side, which we will

1 continue to do, and are happy to report back to the Board  
2 if -- as we -- as we learn more.

3 CHAIRPERSON FECKNER: Thank you. And I would  
4 like to add as part of committee direction that we want to  
5 look at the plans and whether or not they're giving the  
6 right information, that they have the right doctors out  
7 there, whether or not they have enough doctors, and when  
8 they're sending people out of network when they shouldn't  
9 be. So I want to make sure we're keeping our tabs on  
10 that.

11 And as well, I know it's not for, but it was  
12 Committee direction that those plans that have not  
13 partnered with you and your team need to by July. So I  
14 know that's not your direction, but that's my direction to  
15 the plans.

16 So seeing nothing else, Ms. Middleton, when would  
17 you like to start Risk and Audit?

18 BOARD MEMBER MIDDLETON: I think everyone could  
19 use the break, so --

20 (Laughter.)

21 BOARD MEMBER MIDDLETON: -- it's 3:15 now. Let's  
22 start Risk and Audit, which will begin in open session at  
23 3:30.

24 CHAIRPERSON FECKNER: Very good. We thank  
25 everybody for your attention today and we will see you at

1 Risk and Audit at 3:30. This meeting is adjourned.

2 (Thereupon California Public Employees'  
3 Retirement System, Pension and Health Benefits  
4 Committee open session meeting adjourned  
5 at 3:15 p.m.)

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