MEETING

STATE OF CALIFORNIA

PUBLIC EMPLOYEES' RETIREMENT SYSTEM

BOARD OF ADMINISTRATION

PENSION & HEALTH BENEFITS COMMITTEE

OPEN SESSION

ROBERT F. CARLSON AUDITORIUM

LINCOLN PLAZA NORTH

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SACRAMENTO, CALIFORNIA

TUESDAY, APRIL 16, 2019

9:00 A.M.

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

A P P E A R A N C E S

COMMITTEE MEMBERS:

Ms. Rob Feckner, Chairperson

Mr. Ramon Rubalcava, Vice Chairperson

Ms. Margaret Brown

Mr. Henry Jones

Mr. David Miller

Ms. Eraina Ortega

Ms. Mona Pasquil Rogers

Ms. Theresa Taylor

Ms. Betty Yee, represented by Ms. Karen Greene-Ross

BOARD MEMBERS:

Ms. Dana Hollinger

Mr. Jason Perez

Mr. Bill Slaton

STAFF:

Ms. Marcie Frost, Chief Executive Officer

Ms. Liana Bailey-Crimmins, Chief Health Director

Mr. Matt Jacobs, General Counsel

Ms. Donna Lum, Deputy Executive Officer

Ms. Susanna Bishop, Committee Secretary

Dr. Kathy Donneson, Chief, Health Plan Administration Division

A P P E A R A N C E S C O N T I N U E D

STAFF:

Ms. April Fernstrom, Manager, Heath Appeals Unit

Mr. Rob Jarzombek, Chief, Health Account Management Division

Mr. C.J. Nakayama, Manager, Long-Term Care Program

Mr. Todd Shinohara, Pharmacist

ALSO PRESENT:

Mr. Tim Behrens, California State Retirees

Ms. Nadine Franklin, California School Employees Association

Mr. J.J. Jelincic

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P R O C E E D I N G S

CHAIRPERSON FECKNER: Good morning. We'd like to call the Pension and Health Benefits Committee to order. And the first order of business will be to call the roll.

COMMITTEE SECRETARY BISHOP: Rob Feckner?

CHAIRPERSON FECKNER: Good morning.

COMMITTEE SECRETARY BISHOP: Ramon Rubalcava?

VICE CHAIRPERSON RUBALCAVA: Good morning. Here.

COMMITTEE SECRETARY BISHOP: Margaret Brown?

COMMITTEE MEMBER BROWN: Here.

COMMITTEE SECRETARY BISHOP: Henry Jones?

COMMITTEE MEMBER JONES: Here.

COMMITTEE SECRETARY BISHOP: David Miller?

COMMITTEE MEMBER MILLER: Here.

COMMITTEE SECRETARY BISHOP: Eraina Ortega?

COMMITTEE MEMBER ORTEGA: Here.

COMMITTEE SECRETARY BISHOP: Mona Pasquil Rogers?

COMMITTEE MEMBER PASQUIL ROGERS: Here.

COMMITTEE SECRETARY BISHOP: Theresa Taylor?

COMMITTEE MEMBER TAYLOR: Here.

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

ACTING COMMITTEE MEMBER GREENE-ROSS: Here.

CHAIRPERSON FECKNER: Thank you.

Would you please note for the record that Mr.

Perez, Ms. Hollinger and Mr. Slaton have joined the Committee this morning.

Item 2 is the approval of the 2006 -- or the April 16th, Pension and Health Committee timed agenda.

COMMITTEE MEMBER TAYLOR: Move approval.

COMMITTEE MEMBER MILLER: Second.

CHAIRPERSON FECKNER: Moved by Taylor, seconded by Miller.

Any discussion on the motion?

Seeing none.

All in favor say aye?

(Ayes.)

CHAIRPERSON FECKNER: Opposed, no?

Motion carries.

Item 3, Executive Report. Ms. Bailey-Crimmins and Ms. Lum, please.

DEPUTY EXECUTIVE OFFICER LUM: Good morning, Mr. Chair and members of the Committee.

CHAIRPERSON FECKNER: Good morning.

DEPUTY EXECUTIVE OFFICER LUM: Donna Lum, CalPERS team member. I have one very brief update to share with you this morning. And it's related to the CalPERS Benefit Education Event that we held in Eureka on March 22nd and 23rd. If you recall last month, I mentioned that this is one of our most remote Northern California locations, as

the nearest regional office is here in Sacramento. And it's about a five to five and a half an hour drive. I'm happy to share with you that once again we have broken another record for attendance at a CBEE. Our prior record in Eureka was about 426 attendees. And at this CBEE, we had nearly 600.

(Wows.)

DEPUTY EXECUTIVE OFFICER LUM: So again, being that far north, our members really, really do appreciate when we host events like this. And they really do come in force to get the information that they need. We did notice that in the working sessions that we had that these members were very engaged. They asked a lot of really good questions. And they also took a lot of time to visit the exhibit halls and to interact with our team members, and the exhibitors that we have there as well. So again, I just wanted to share with you that that was a very successful event.

And then just one very fun highlight that the team members had. And they had a great sense of provide when this took place. We had a member who had about 30 years of -- 37 years of service. And he had a lot of questions about planning for retirement. Our team members actually helped him to establish my|CalPERS account while he was at the event. He happened to be there with his

wife. They assisted him with running a retirement estimate. They answered questions about beneficiary designations, and power of attorneys, and other really relevant information that our members need when they're making an important decision like retirement.

And by the end of the day, he had made his decision, along with this wife, to retire. And they went on to assist him with his retirement application. So this is just again an example of how our members truly do benefit from the resources that we put into these events. And in the case of Eureka being again as far north as they are, they really did appreciate our presence.

So as a reminder to our members, those watching the webcast and the audience here, we do have our entire CBEE schedule posted on CalPERS online. And so again, we encourage you to look at the schedule. And if you're in a location near one of the CBEEs within a reasonable traveling distance, we do encourage you to attend. There's a lot of information that you can gain. And these CBEEs are also targeted for members that are in their mid to early career, as well as those that are nearing retirement. There's a lot of information that can be gleaned out of these sessions to help plan for retirement.

So, Mr. Chair, that concludes my presentation and I'm available to answer any questions.

CHAIRPERSON FECKNER: Thank you. I just want to comment that I was contacted here in this last month by a member who was in the hospital, been in the hospital for 30 days, and didn't look like they were going to get out any time soon. So through communications, your staff was able to go from San Jose to the hospital in Santa Cruz to retire that person. And I just want to say what a -- what a great service that was. The person has now passed away. But the service was done and his wife was taken care, so thank you and your staff.

DEPUTY EXECUTIVE OFFICER LUM: Thank you. And I'll go -- I'll share that information with the team.

CHAIRPERSON FECKNER: Please do.

Ms. Bailey-Crimmins.

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: Good morning, Mr. Chair and members of the Committee. Liana Bailey-Crimmins, CalPERS team member. On our agenda today, we have three action items before you. The first two are our proposed revisions to the Public Employees Medical and Hospital Care Act, also known as PEMHCA. The first proposal would allow CalPERS to grant members an additional 30 days to request a CalPERS administrative review on an appeal.

Currently, PEMHCA only allows these extension requests for an administrative hearing. And we believe

having an additional 30 days for the review process will be a benefit to our members.

The second proposal addresses technical changes to bring the regulation into alignment with current law, such as ACA, and remove outdated terms and references to statutes that no longer exist.

The third action is a relation to a benefit enhancement for the CalPERS Long-Term Health Care Program. This new offering would be a fall prevention program. Its called LIFT Wellness, and it would be available to Long-Term Care members over the age of 75. This is a national program designed by experts to help reduce the risk of falls and fractures, so our Long-Term Care members may remain independent in their homes for as long as possible.

And finally, we have good news to share with you in relation to the CalPERS efforts in managing opioids on behalf our members. As a reminder, at the last July offsite, we gave you highlights on our successes that -- with Kaiser. Well today, you're going to hear our successes with our pharmacy benefit manager, OptumRx.

So Mr. Chair, that concludes my opening remarks and I'm available for any questions.

CHAIRPERSON FECKNER: Very good. Thank you.

Seeing none.

Brings us to Agenda Item 4, the action consent items. Having had no request to remove anything, what's the pleasure of the Committee?

COMMITTEE MEMBER JONES: Move it.

COMMITTEE MEMBER TAYLOR: Second.

CHAIRPERSON FECKNER: Moved by Jones, seconded by Taylor.

Any discussion on the motion?

Seeing none.

All in favor say aye?

(Ayes.)

CHAIRPERSON FECKNER: Opposed, no?

Motion carries.

CHAIRPERSON FECKNER: Item 5, the information consent items. Having not request to move anything, it brings us to Agenda Item 6, starting with the action items.

We have 6a, Proposed Revisions to the PEMHCA Rules. Ms. Donneson.

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Thank you, Mr. Chair. Members of the Committee, Kathy Donneson, CalPERS team member.

Agenda Item 6a is a proposal to make some technical revisions to the Public Employees Medical and Health Care Act, or PEMHCA. This agenda item is an action

item, in which we will recommend these technical changes that will enhance support of our appeals program for our members.

The technical change we request is meant to align two sections of one Government Code 599.51(a). In the (a) section of the Government Code, that is the administrative review portion of a member's right to appeal. And within that 30 days, they can come to us after a determination has been made to request an administrative review.

If they go beyond 30 days in that request, we technically do not have the approval to grant any type of additional time. But section (e) of the same Government Code states that they may request an administrative hearing within writing within 30 days of the administrative review decision.

So in one hand, we have a 30-day under (a) for them to file the appeal, but not the ability to grant any extending time, but in (e) in order to go to the next step request an administrative hearing, we do have the opportunity under the Government Code to allow an exception process for more time.

So in summary, this agenda item aligns those two sections so that our members, if they have complicated cases or they missed their filing under (a) for review, they have an additional amount of time to meet that review

process, and then move on to the administrative hearing, should they wish to do so.

That's the essence of the technical change, and we do request approval.

Are there any questions

CHAIRPERSON FECKNER: Thank you.

Ms. Brown

COMMITTEE MEMBER BROWN: Thank you, Ms. Donneson. Did this change come about as a result of sort of audit findings that said that we were extending some or we weren't following the section (a), is that -- is that correct?

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Yes, ma'am. It did come as a technical finding within an audit. And we did look at the alignment and want to make sure that when -- we're meeting our requirements to clear the audit, as well as give our members more time to follow the full process.

COMMITTEE MEMBER BROWN: I think that's excellent that we're -- are going to allow them an additional 30-day extension. My concern is if we have any denials in the past where they didn't appeal within 30 days or they didn't -- they didn't follow -- or they followed (a) exactly and we denied them, because they came in at 35 or 40 days. Now, I know the audit said you were allowing

those appeals, even though they were beyond the 30 days. So I just want to make sure there isn't anybody that we denied, because they were at 40 days or 50 days. They'll get a chance maybe to come back. I just -- is this --

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: I believe that if there were, they're small. But I do have my appeals manager here, and perhaps she could address that.

COMMITTEE MEMBER BROWN: I just hope we'd apply it maybe retroactively, if it's not a big group.

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Let's go back. This is April Fernstrom. She's the manager of the appeals process.

CHAIRPERSON FECKNER: Microphone.

HEALTH APPEALS UNIT MANAGER FERNSTROM: Hi. Good morning.

There we go. Hi. Good morning, everyone. Thank you for your question.

So in the past we were considering extenuating circumstances for members who came to us outside of the 30-day time frame. So we could certainly take a look back at our previous appeals that were received out of that time frame and review how we made our determination. But because of the audit, that was one of the things that came to light is that we were accepting them in cases showing

good cause.

COMMITTEE MEMBER BROWN: I really appreciate that you were giving members benefit of the doubt, and that we're going to align our regulations in PEMHCA. I would just hope that we would retroactively just go back and look and maybe just let us know -- it wouldn't need to be a presentation, but just let us know if there's anyone else that we could take a look at. We want to try and help our members where -- and I know that's why we got in trouble, so -- but thank you.

HEALTH APPEALS UNIT MANAGER FERNSTROM: We agree. Yes.

COMMITTEE MEMBER BROWN: Okay. Thank you.

CHAIRPERSON FECKNER: Thank you.

Seeing no other requests to speak, what's the pleasure of the Committee?

VICE CHAIRPERSON RUBALCAVA: Move the staff recommendation.

CHAIRPERSON FECKNER: It's been moved by Rubalcava.

Second?

COMMITTEE MEMBER MILLER: Second.

CHAIRPERSON FECKNER: Seconded by Miller.

No discussion -- any discussion on the motion?

Seeing none.

All in favor say aye?

(Ayes.)

CHAIRPERSON FECKNER: Opposed, no?

Motion carries.

That brings us to Agenda Item 6b, the revisions to PEMHCA and various technical revisions.

Ms. Little. No, Mr. Jarzombek. That's what happens when we list more than one name.

HEALTH ACCOUNT MANAGEMENT DIVISION CHIEF JARZOMBEK: Good morning, Committee Chair, Committee Members. Rob Jarzombek, CalPERS team member.

I'm presenting Agenda Item 6b, which is an action item requesting your approval to pursue technical and non-substantive changes to regulations affecting the CalPERS Health Benefits Program.

These changes have been identified as outdated for a variety of reasons, and they fall into three basic categories. The first category is revisions. We're proposing changes or revisions to subsections that are outdated. The second category is removals. We recommend removing or eliminating sections and references that are no longer applicable. And the last category is relettering. So based on removing some sections, subsequent sessions need to the simply be relettered.

So for the first category, the sections we

proposed revising, here are a couple of examples of what they contain. Subdivision (b) of section 599.501 contains outdated terminology that is no longer used to describe individuals with a disability. The term "handicapped" is no longer used when describing a person who is either blind, deaf, or disabled.

In subdivision (g) of that same section, we propose to update the timeline to submit recertification documents for disabled dependents. This change will make the recertification process -- the recertification time frame consistent with those for submitting documents for parent-child relationships, as well as dependent eligibility verification. So this change will reduce complexity in our program by using a standard time frame for all recertification processes.

As far as the second category, removing sections, we propose to delete a subdivision that gives the appearance that certain annuitants are ineligible for CalPERS health benefits. For example, subdivision (c) of 599.501 states that a retiree whose monthly retirement allowance is insufficient to pay the premium of the lowest cost health plan is ineligible for CalPERS health benefits.

This provision was removed with the development of the Complementary Annuitant Premium Program, or the

CAPP program. The CAPP program allows retired members to continue their health coverage by paying CalPERS the balance of the premium owed, regardless of which health plan they choose.

Similarly, we propose to delete inaccurate information in subdivision (e) of the same section, as it too gives the appearance that certain annuitants are ineligible for CalPERS health benefits. This regulation reflects that members who are not enrolled in a CalPERS health plan at the time of separation from employment are not eligible for CalPERS health benefits in retirement.

However, other provisions within PEMHCA specified that annuitant -- an annuitant may enroll during any future open enrollment period, thus contradicting this subdivision. We propose deleting this language.

And finally, the third category, relettering. We propose to reletter -- reletter sections impacted by the removal of code sections and update various cross-references found throughout the regulations. The majority of the changes we're actually pursuing fall into this category.

There are numerous benefits to pursuing these changes. These changes will allow CalPERS to better maintain accuracy in our regulations; it will minimize confusion amongst members, employers, as well as CalPERS

team members, it addresses an observation made last year through an internal audit; and it eliminates outdated statutory requirements.

If the Committee approves these changes, we'll submit our public notice hack page to the Office of Administrative Law and proceed with a 45-day comment period. At this time, we do not anticipate any comments.

At the end of the comment period, we'll return to the Committee and request approval of the final rulemaking file. This concludes my presentation, and I'm happy to answer any questions.

CHAIRPERSON FECKNER: Thank you.

Ms. Brown.

COMMITTEE MEMBER BROWN: Mine are pretty simple. On the regulation that says an annuitant may enroll, if not enrolled, can you tell me what that regulation section is?

Oh, it's not that easy okay.

HEALTH ACCOUNT MANAGEMENT DIVISION CHIEF JARZOMBEK: Off the top of my head, it is -- may enroll -- it's 599.501 subdivision (e).

COMMITTEE MEMBER BROWN: 599.501 subdivision (e)?

HEALTH ACCOUNT MANAGEMENT DIVISION CHIEF JARZOMBEK: Yes.

COMMITTEE MEMBER BROWN: Okay. And are we -- is

the change that they may enroll, if they're currently not enrolled at any open enrollment time?

HEALTH ACCOUNT MANAGEMENT DIVISION CHIEF JARZOMBEK: Yes.

COMMITTEE MEMBER BROWN: That is the chance, so they may?

HEALTH ACCOUNT MANAGEMENT DIVISION CHIEF JARZOMBEK: They may and they also may enroll during any qualifying event.

COMMITTEE MEMBER BROWN: Like marriage.

HEALTH ACCOUNT MANAGEMENT DIVISION CHIEF JARZOMBEK: Correct.

COMMITTEE MEMBER BROWN: Or birth?

HEALTH ACCOUNT MANAGEMENT DIVISION CHIEF JARZOMBEK: Correct. So it's open -- it's clarifying this one that said they aren't, and falls in line with the rest that say that they are and has been our practice.

COMMITTEE MEMBER BROWN: Great. Thank you.

CHAIRPERSON FECKNER: Thank you. I have -- let's see anybody else from the Board?

Mr. Jones.

COMMITTEE MEMBER JONES: Thank you, Mr. Chair.

Move approval.

COMMITTEE MEMBER BROWN: Second.

CHAIRPERSON FECKNER: All right. It's been moved

by Jones, seconded by Brown.

Mr. Rubalcava.

VICE CHAIRPERSON RUBALCAVA: I had a question, but mine are -- it will not delay the enactment of our --

CHAIRPERSON FECKNER: Ask your question.

VICE CHAIRPERSON RUBALCAVA: I just want to make sure one kind -- in general, in totality, all these are good changes for the members. And I support them of course.

But I just want a little history on 599.0502, subdivision (c), it seems to ask like for permission from the carrier for -- is it like -- is it outdated preexisting conditions, is that what that is?

HEALTH ACCOUNT MANAGEMENT DIVISION CHIEF JARZOMBEK: Yes. So this is -- this is --

VICE CHAIRPERSON RUBALCAVA: And that's illegal now anyway.

HEALTH ACCOUNT MANAGEMENT DIVISION CHIEF JARZOMBEK: Correct. And it changed with HIPAA coming to -- going into effect in 1998, and then also with the ACA. So this is -- again, this is just clean up -- cleaning up the regulation so they reflect all the current law.

VICE CHAIRPERSON RUBALCAVA: No, I understand it's cleanup. I just want to make sure people understand

that this is definitely advantageous for the members.

HEALTH ACCOUNT MANAGEMENT DIVISION CHIEF JARZOMBEK: Yes.

CHAIRPERSON FECKNER: Very good.

VICE CHAIRPERSON RUBALCAVA: And I support Mr. Jones -- President Jones' motion.

CHAIRPERSON FECKNER: Thank you.

Seeing no other questions from the Board. We do have one request from the audience. J.J. Jelincic. Pease come down to my left. You'll have up to three minutes. Please state your name for the record.

MR. JELINCIC: I'm Joseph John Jelincic, Jr., better known as J.J.

The presentation of this regulation cutting out sections saves a lot of trees, and I understand why it was done. However, one of the problems that gets missed when you do that is currently 559.501(a) refers to both (b) and (c). And this proposal is to eliminate (c), and renumber it so it's now a different (c). And so I would encourage you to fix that before it went to the Office of Administrative Law.

CHAIRPERSON FECKNER: Thank you.

Mr. Jarzombek, any comment?

HEALTH ACCOUNT MANAGEMENT DIVISION CHIEF JARZOMBEK: I believe we were going to update that, but

I'll take that back to ensure that's included.

CHAIRPERSON FECKNER: Very good. Thank you.

Seeing no other requests. Motion being before you.

All in favor say aye?

(Ayes.)

CHAIRPERSON FECKNER: Opposed, no?

Motion carries.

Thank you.

6c, Long-Term Care Benefits Update. Ms. Donneson.

(Thereupon an overhead presentation was presented as follows.)

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Mr. Chair, members of the Committee, this is another action item the team is bringing forward. This agenda item discusses a long-term care benefit change design to reduce claims associated with falls, gait anomalies, and imbalance for our members in the Long-Term Care Program.

Courtney J. Nakayama, who we also call C.J. will make this presentation, and then we'll be available to answer your questions. Upon conclusion, we would like to ask you to approve this agenda item.

C.J.

LONG-TERM CARE PROGRAM MANAGER NAKAYAMA: Mr, Chair, members of the Committee. C.J. Nakayama, CalPERS team member with the Health Plan Administration Division. Today, I'll be presenting, as Kathy said, Agenda Item 6c, an action item for long-term care benefit updates. At the conclusion, we'll ask that you approve our team's recommendation.

This item aligns with CalPERS Strategic Plan goal of health plan affordability. And today, I will cover the LIFT Wellness program, why there is a focus on falls, goals and components of the program, and lastly, next steps.

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LONG-TERM CARE PROGRAM MANAGER NAKAYAMA: The LIFT Wellness program is a proactive pre-claim intervention program that's focused on one of the major causes of long-term care claims, falls and fractures. It is designed to prevent falls, keep participants functioning independently, and lower long-term care claims.

The program was originally developed in 2004 in a collaboration between the U.S. Department of Health and Human Services, and our third-party administrator LTCG. Program development was guided by an appointed technical advisory group comprised of fall prevention experts, based

on extensive literature review, and founded upon best practices.

It's an evidence-based program, and in the original pilot produced an 18 percent reduction in injurious falls, a 33 percent reduction in long-term care claims over a three-year period, and participants in the program were 20 percent more likely to make fall-preventing home modifications than those who did not participate.

So why focus on falls? As we age, we are more susceptible to falls, gait anomalies and imbalance. This is especially true for those over the age of 75. In this chart, you can see the total -- the cumulative total claims that were open at the end of each calendar year.

And, in fact, from program inception through December 31st of 2017, claims due to falls, gait anomalies, and imbalance comprised 21 percent of CalPERS total paid long-term care claims. This amounted to over $490 million.

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LONG-TERM CARE PROGRAM MANAGER NAKAYAMA: So the goals of the program are really simple. They're to prevent falls, promote wellness, reduce health and long-term care costs, and help keep participants living independently and in their home for longer.

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LONG-TERM CARE PROGRAM MANAGER NAKAYAMA: The program consists of multiple components consisting of member engagement. This would be done through mail, as well as by phone. Once somebody enrolls in the program, they would receive an in-home assessment. From this in-home assessment, an individualized plan is created for the participant and it's shared with them as well as their physician. And when they receive this plan, they get a LIFT Wellness toolkit that includes a pedometer, a night light, magnifying glass, water bottle, literature about -- to educate the participant about the risk of falling, exercises to improve balance, and tips to remain safe and living in one's home. This is all followed by 12 months of support and ongoing telephonic coaching.

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LONG-TERM CARE PROGRAM MANAGER NAKAYAMA: In this chart, we see four different scenarios based on different enrollment rates. If we focus on the 20 percent enrollment rate, the cost would be approximately $5 million, and the estimated net savings between 6 and 12.7 million dollars. This would produce a return on investment from 120 to over 200 percent.

But in the end, it really isn't just about the numbers. But about being able to help our long-term care

participants to remain safe and functionally independent in their home.

--o0o--

LONG-TERM CARE PROGRAM MANAGER NAKAYAMA: So if approved, the next steps would be to finalize the program charter and begin communication and outreach. This outreach would be to those 75 years of age and older, who've had a long-term care policy for at least seven years, are not in claim, and reside in California.

There are over 45,000 CalPERS long-term care participants that would be eligible for this program, and they would be phased in over a three-year period based on enrollment rates and operational limitations.

Once someone is enrolled and receives an in-home assessment, a LIFT Care advisory fee would be billed directly to the program. The member would not receive a bill.

Throughout the program, we will continue to monitor it through a variety of monthly and quarterly reports. And upon completion, we would do a comprehensive assessment.

At this time, I recommend approval of the LIFT Wellness program. This completes my presentation, and I'm available for questions.

CHAIRPERSON FECKNER: Thank you.

Ms. Brown.

COMMITTEE MEMBER BROWN: Thank you.

Can you tell me why only in California? A lot of our members in the Long-Term Care Program reside outside of California. I found this out. Personally, last week, I visited two RPEA chapters in the Albuquerque and Los Alamos. And I will tell you I had so many questions about long-term care, I'm going to need some education about that, because their primary concern was some of these are our most senior members. And they entered the Long-Term Care Program when they had to choose between assisted living or in-home. And they have real concerns about the grandfathering. So I want to get an education about that.

But also, we do have a lot of members outside of California. So is there a reason why we can't offer it to them as well?

LONG-TERM CARE PROGRAM MANAGER NAKAYAMA: The way the program was proposed by the third-party administrator for operational reasons is with the bulk of the people being here and having to have nurses physically go to a -- to the participant's house to do an in-home assessment, operationally, at least at this period of it, it wouldn't be as cost effective to try to spread it nationwide, but to focus on where our primary concentration of long-term care participants are.

And while you look at it, this is for the long-term care participants. So we have -- while we do have quite a few that live out of state, primarily they live within California.

COMMITTEE MEMBER BROWN: Maybe we could look at the data and see if we could -- if we know that we need to have, let's say, 20 participants within a 20-mile radius, if we could gather -- get that many people, maybe we could offer it to them. Just take a look at the data, the analysis to see. And maybe we start it in California and look to -- okay. Go ahead, Kathy. I think you're going to tell me about -- I love data.

(Laughter.)

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: I was -- I was about to agree with you. Yes, we should start it in California. It's voluntary. We need to see what the uptake is. And so we concentrate for efficiency purposes where we started, which is here, but it doesn't mean it has to stay here, that it could be looked upon beyond the California borders.

COMMITTEE MEMBER BROWN: Great. And I know we're looking at cost effectiveness. But also maybe even if we go out of state, maybe break -- break even, right? So that way -- or even if it cost us a little, it might be helpful to have. I know they're concerned about falling.

I mean, they really are concerned about injuring themselves, and they want to stay in their home.

So the more we can offer cost effectively, the better. So I appreciate you continue to look at that. Thank you.

CHAIRPERSON FECKNER: Thank you.

Mr. Miller.

COMMITTEE MEMBER MILLER: Yeah. Thank you for this. I have a few comments and a question or two. I'm very, very engaged with the long-term care community. And the -- I think you emphasized, and I can't understate, the importance of preventing falls, both in the home, but also in institutional settings. And not only because of the impact of falls, no pun intended, on the person falling, but they're also a huge contributor to injuries, lost time, disability, et cetera for health care workers, and family members. And everyone both at home and institutional, falls are a huge, huge problem. And I applaud you for recognizing that and looking for what we can do.

In the industry, there's also a couple kind of real -- there's a lot of potential for technological disruption, both active and passive technologies, for addressing falls, potential for falls, identifying who is more at risk than who, and kind of tracking the change

over the -- over time, as partly as a way to engage patients -- potential patients, but partly as a way to focus resources.

And so I hope as this develops, certainly in the industry, that we're really looking at those trends of new approaches to the whole subject of falls. For the last 50 years or so, much of it was just focused on -- as behavioral and, you know, lift machines, and belts, and all those type of things, but it's much more moving into high tech.

And so that leads to my question, which is in looking at this, was this just something that a potential provider came to us? Did we reach out? Were there alternatives that we looked at and put this one forward? Just kind of curious about the process by which this came to us. And I am very supportive of it.

LONG-TERM CARE PROGRAM MANAGER NAKAYAMA: Yeah. Our third-party administrator, LTCG, had recently acquired LifePlans, Inc., who helped develop this program, who was initially part of Long Term Care Group, but then split apart part way when they were bought by Univita. But they had developed this program back in 2004 and ran a pilot from 2008 to 2012.

During one of our quarterly business reviews, where we talk about, you know, industry standards and

things moving forward, they brought this program in front of us. And the numbers, what it focused on, and helping our participants to remain functionally independent focusing, like you said, on one of the major causes, falls and fractures, we thought it was a great program, something that would benefit, not only our members, but our Long-Term Care Program as well. And that's how it came about.

CHAIRPERSON FECKNER: Thank you.

Ms. Greene-Ross.

ACTING COMMITTEE MEMBER GREENE-ROSS: This sounds like a very helpful program for reducing the claims -- the cost of claims. Just want to make sure that it's voluntary only, and that there is never going to be any penalty for members who were reached out to participate in California, that they would ever be denied claims because they didn't participate?

LONG-TERM CARE PROGRAM MANAGER NAKAYAMA: No. This is a 100 percent voluntary program. There's no penalty. Even if somebody enrolls in the program, there's no cost to them either. So there's no adverse action if somebody does not choose to participate, only the benefits of getting the education and the ongoing support, if they choose to.

ACTING COMMITTEE MEMBER GREENE-ROSS: Have you --

hope you have that in good legal writing.

(Laughter.)

ACTING COMMITTEE MEMBER GREENE-ROSS: Thank you.

CHAIRPERSON FECKNER: Thank you.

Seeing no other requests, I do have one request from the audience. Tim Behrens, please come forward. You'll have up to three minutes.

MR. BEHRENS: Good morning, Chairman Feckner and Committee. Tim Behrens, the President of California State Retirees. I applaud this plan. I think it's a great plan. I would like to see some consideration given in the future to provide this same type of training to all of our stakeholders, because loss of balance and falling are inevitable for us as we get older.

And I think this really has a lot of merit. CalPERS has always kind of led in preventative medicine, led for preventative plans. You provided the SilverSneakers program to all of our stakeholders. I'd like to see some consideration in the future in making this same kind of training available to all of our stakeholders.

Thank you.

CHAIRPERSON FECKNER: Thank you.

Seeing no other requests to speak.

The motion being before you.

COMMITTEE MEMBER TAYLOR: Move approval.

COMMITTEE MEMBER PASQUIL ROGERS: Second

CHAIRPERSON FECKNER: Moved by Taylor, second by Pasquil Rogers.

Any discussion on the motion?

Seeing none.

All in favor say aye?

(Ayes.)

CHAIRPERSON FECKNER: Opposed, no?

Motion carries. Thank you.

That brings us to 7a, Opioid Management Update. Ms. Donneson.

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: Mr. Chair and members of the Committee. Kathy Donneson, CalPERS team member. Mr. Todd Shinohara, who's to my left will make the presentation. But I would like to give some opening remarks before I gave it -- turn it to Todd.

This agenda item provides an update for how OptumRx is aligning our PPO and HMO pharmacy management with the Centers for Disease Control and Prevention guidelines. At the July offsite in 2018, I made a presentation to the full Board on what our program has historically done to identify use, prescribing, and cost associated with opioids for CalPERS.

The data we presented at the time at that offsite was for the full -- our full membership, even though I co-presented with Kaiser who also runs the same type of opioid management program, as does Blue Shield. So I just want to make sure that this is about our OptumRx program, but we align all of our opioid management under -- under a single CalPERS umbrella.

Today, we look at the Optum program, which manages the pharmacy benefit for approximately 500,000 basic and Medicare members. And as I said, Todd Shinohara, who is a new pharmacist with CalPERS, having joined us about six months ago, is going to make this presentation, and then we will answer questions for you.

Todd.

(Thereupon an overhead presentation was presented as follows.)

MR. SHINOHARA: Good morning, Mr. Chair and members of the Committee. Todd Shinohara, CalPERS team member.

This agenda item is an update on how CalPERS and OptumRx are managing opioids for our members. So, first, our philosophy is focused on stopping opioid abuse before it starts, at the same time, supporting members and their family members who may be battling dependence issues as well as in recovery. The focus is really towards safety

and prevention through engagement, smart prescribing, and ongoing monitoring. Finally, the opioid risk management program by OptumRx aligns with CalPERS' strategic measures in the Smart Care of California Initiative.

Before I go on, I want to point out that OptumRx was recently recognized with the excellence award for opioid management strategies at the 2019 Pharmacy Benefit Management Institute national convention in Palm Springs.

Optum received the award where 96 percent of opioid prescriptions written by prescribers were found to be aligned with CDC best practice for duration and dosage compared to the national average of 55 percent. So kudos and congratulations to OptumRx.

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MR. SHINOHARA: We educate members, prescribers, and pharmacies using multiple channels and touchpoints. And through education, what we've seen is a reduction of opioid claims and patients by 19 percent and 15 percent. We believe by educating and empowering, we're driving to create a more educated prescriber, highlighting safer alternatives, and more prudent prescribing of opioid medications, as measured in six months in 2017 compared to 2018 for our basic plans.

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MR. SHINOHARA: One of CalPERS strategic measures

is to reduce the overuse of ineffective or unnecessary medical air. Through education, the average morphine milligram equivalent utilization per day decreased by 14 percent. And the -- and we also saw a 32 percent decrease in adults with a very large dose of greater than 15-day supply, and greater than 120 milligram equivalents per day.

This is really significant, because the higher dose equals the higher risk. We attribute these results to education on appropriate use and duration for opioids. And allow me to point out, before I move off this slide, that the MME is really a conversion tool that equates many different types of opioids into really one standard value. And that standard value is morphine. And it's potency is referred to as MME, or morphine milligram equivalent.

So, for example, hydrocodone is equivalent to morphine at a 1-to-1. So 120 milligrams of hydrocodone is equal to 120 milligrams of morphine or 120 morphine milligram equivalents.

If you allow me to put my pharmacist hat on. If you're looking at hydrocodone at 5 milligrams, that equals approximately 24 tablets. But also it means if you're looking at hydrocodone at 10 milligrams, you're looking at 12 tablets. So it's not necessarily the number of tabs, but it's the total morphine milligram equivalent per day

that we should be looking at, which we are, okay?

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MR. SHINOHARA: So next. The risk of opioid addiction increases with each additional day of opioids starting after the third day. So it's critical that our physicians and other prescribers focus in on this morphine milligram equivalents dose and duration at the very first prescription.

So at the heart of the program, minimizing early exposure to opioids reduces inappropriate supplies, which are two of the CDC recommendations in terms of reducing opioid dependence and opioid burden. So some of the highlights I want to share first include the first point, the number of new patients with greater than 50 MMEs per day. Well, that decreased -- those number of prescriptions decreased by 86 percent and not 18 percent as listed on the slide here.

So let me step back and put that in perspective. What that means is the normal dose is normally less than 50 morphine milligrams equivalents per day. And we know, based on evidence, that the risk of overdose -- overdose increases two-fold when your at or above 15 MMEs per day. So 86 percent is a good number.

Second, the number of new patients with greater than a 7-day supply decreased by 73 percent. So that

decreases supply that's -- could be potentially inappropriate.

And third, the total opioid use greater than 90 MME per day decreased by 48 percent. 90 MME per day is a high dose. So as you know, the higher the dose, that higher the risk.

So again, minimizing early exposure and reducing inappropriate supplies are at the heart of the program, as well as the emphasis toward that patient-physician relationship.

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MR. SHINOHARA: Recognizing the high rate of relapse with opioid abuse, our focus further helps build more and effective sustainable recovery by aggressively promoting practice guidelines and interventions. Our members, physicians, and other prescribers are provided unrestricted access to drugs like methadone, naloxone, buprenorphine, which are used to wean patients from opioids and avoid overdose and relapse.

These drugs, in combination with counseling and behavioral therapies, provide a whole patient approach to treatment of substance abuse disorder.

So looking at our first year results, indicate that our members and prescribers have been appropriately taking advantage of these very important programs.

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MR. SHINOHARA: Safety initiatives. Two recent safety initiatives have been really implemented to educate members and to reduce the inappropriate supply of opioids at the home.

First, OptumRx Home Delivery Pharmacy is using a warning label located on the underside of the vial cap. And this is in addition to all the warning labels that are seen on the outside of the vile.

And second, to dispose of unused or outdated prescription medications, OptumRx is providing a medication disposal option the Deterra kit. The kit contains really water soluble pods containing activated carbon. A three-step process that includes placing the drugs into the pouch, adding warm water, closing the pouch, renders the medication that you put in there unretrievable and inert, and it doesn't harm the environment.

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MR. SHINOHARA: And finally, future enhancements or next steps that we're looking at really include follow-up on rejected claims, such as methadone, naloxone, buprenorphine that we discussed earlier.

Secondly, identify members who are at high risk for misuse. Enhance point of sale capabilities by

integrating data from medical and pharmacy to identify additional safety concerns at that point of sale. And finally, further notification of -- to our prescribers and education.

So the future enhancements for opioids being explored, focus on prevention, education, and safety for prescribers, members, and their extended families with prescriptions or access to opioids.

So that concludes my presentation, Mr. Chair. And I'll be happy to take any questions.

CHAIRPERSON FECKNER: Thank you.

First of all, very impressive numbers, so thank you for the presentation. And I will say that at this year's employer's forum in the vendor room, they were actually handing out those Deterra kits. So that was a good way to bring that out into the community and educate our members when they attended.

Ms. Taylor.

COMMITTEE MEMBER TAYLOR: Yes. Thank you. Thank you very much for your presentation. They are very impressive numbers. I just -- I'm trying to find the page I was looking at. I just had a couple of questions.

On page four, so new users 50 MME per day has decreased by 18 percent, but you were talking about --

MR. SHINOHARA: 86 percent. That's a misprint on

the slide.

COMMITTEE MEMBER TAYLOR: Oh, 86 percent.

MR. SHINOHARA: Yeah.

COMMITTEE MEMBER TAYLOR: So let me write that down. So I guess new users would that be somebody who's just come out of surgery, is that what you mean by that?

MR. SHINOHARA: New users are generally those persons who are opioid naive?

COMMITTEE MEMBER TAYLOR: I'm sorry?

MR. SHINOHARA: Opioid -- who haven't used opioids before in the past.

COMMITTEE MEMBER TAYLOR: Ever used opioids.

MR. SHINOHARA: Right. So this is their first -- first --

COMMITTEE MEMBER TAYLOR: So it would -- for whatever reason they were prescribed, and we're -- we're -- with -- through this program, we're working to get them down -- well, to introduce them to less than 50 milligrams as opposed to, I assume that you used to be different. They used to introduce new patients to a higher milligram?

MR. SHINOHARA: So generally, the -- the normal dosing for opioids are -- generally, range between 20 MME per day to 50. And then anything above 50 has that increased higher risk. So the focus is toward really

lower duration and lower doses. So when I went to pharmacy school at the time, you know, there was many standard doses that you just remember, and maybe many of you have seen, 1 to 2 milligrams -- or 1 to 2 tablets every 4 to 6 hours as needed for pain, you know. And they give you number 30 as a standard.

Some people I knew even had a stamp that went that way. So now it's more of how much opioids do you really need for that short duration of time.

COMMITTEE MEMBER TAYLOR: Okay. And for whatever reason, they're introduced to it.

MR. SHINOHARA: Yes.

COMMITTEE MEMBER TAYLOR: And then new users always -- so I ran into this. I have some members that complained to me, 7 day supply. So say you come out of surgery, and that is apparently what the new -- everybody I've talked to that have come to me said they -- they initially get a 7-day prescription, and then they have to go back and ask for more, depending on, you know, the type of surgery and how much pain they're in.

So I'm not -- I'm sure this is effective. It seemed like people were complaining that they not only had to get their doctor to do that, but then they had to get the insurance carrier to approve it for surgeries as complex as bariatric surgery, which is painful, knee and

hip surgeries I've heard from folks. So -- I'm not clear on the benefit of just 7 days, rather than having the doctor, I mean, prescribe what they feel is an appropriate range.

So what's the -- what is -- what are you trying to accomplish by just a 7-day after a surgery or something like -- I get like if you're getting a tooth removed, totally get that, but...

MR. SHINOHARA: Seven days -- really getting below 7 days is -- really should be the goal. And then when you have complex surgeries that go beyond 7 days, then, you know, that really dawns upon the experience of that provider with that patient, and being able to --

COMMITTEE MEMBER TAYLOR: But that's not what they're running into. They're running into -- because of this program probably, they're running -- because these are my employees, right, State workers. So they're running into being told, okay, well, hold on. So they've already run out. Hold on, we got to get permission from the insurance carrier.

So here they are 7 days out of a bariatric surgery, knee surgery, whatever, and these are -- having to wait a couple of days in a lot of pain to get approval and feeling kind of helpless, et cetera. So I get the goal for minor pain incidents. I'm a little concerned

that we're kind of throwing the baby out with the bath water, from what I'm hearing from my members, so...

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: So as you -- this Committee, and for the new members know, we've been working on looking at opioids since the mid-2000s.

COMMITTEE MEMBER TAYLOR: Right.

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: And we do have concern that what was a very generous prescribing program may have gone to --

COMMITTEE MEMBER TAYLOR: The other extreme.

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: -- the other extreme. And so one of -- a couple of things that we want to, as a CalPERS team, to continue to look at, first of all, is their proper pain management. And that really is between the patient and the physician. I would not like to say that our program was denying anything over 7 days. But if that were the case, we have an appeals and grievance program. We would certainly look at that. We would also look at, you know, case management programs, which is part of appeals and grievances.

But also, we're bringing in too a Chief Medical Officer in May, as well as a second medical consultant. And really this -- this is between the patient and the

their physicians. And the physicians themselves are having to deal with these new CDC guidelines, and what is appropriate prescribing.

COMMITTEE MEMBER TAYLOR: Sure.

HEALTH PLAN ADMINISTRATION DIVISION CHIEF DONNESON: What is real patient management for cancer, for end of life, for chronic pain that may have a source that only the physician really realizes what it is.

So we have to be, I think, diligent to know about these things, to keep an eye on any legislation that could be coming through that may have an unintended consequences for the prescribers. These are controlled substances. They're called Schedule II, and therefore it's always been controlled. But we just want to make sure over time, as we bring in our physicians, as we work with health care services, and Covered California under Smart Care California, the California Health Care Foundation is also looking at this.

So we just are going to have to hear about these things, use our appeals and grievances, use our ability to -- for case management with our plans, and follow legislation that may have unintended consequences.

COMMITTEE MEMBER TAYLOR: Right. And I appreciate that. I think that you and I are kind of saying the same thing, that we don't want to have our

patients or our members coming out of surgery and have -- my main thing is I don't -- I think what I'm hearing is not necessarily that the insurance carrier is denying it, but that -- it's taking time. And if they don't know ahead of time, which a lot of our folks don't, that you -- okay. You got 7 days worth, and if their doctor doesn't tell them, and you just came out of whatever surgery, and you know you've got a 3 month or 6 week recovery in pain, they don't know that they would have to, ahead of time, order -- ask their doctor to get this approved, so then they're running out of the pain medication. And I think that's what we're running into there.

And then you addressed my other concern, which is long-term chronic pain that people are in, whether it's cancer, or whether it's just chronic pain due to whatever else they have that we seem to want to get everybody off opioids. But then what do you do with these people that are in long-term chronic pain. And Liana and I have talked about back pain, and it's real, and doesn't go away, and it gets worse as you get older.

But I think that we need to be cognizant of that, and I understand that -- I would hope that, you know, our doctors, are the ones that get to make these calls, and not legislators, or insurance companies. And that's where I'm running into some concerns with this.

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: Ms. Taylor, completely agree. And what we can commit to is, one, looking at the data. I don't want to wait for a member to have to appeal and wait for it. So we can dive in to see if we're seeing that on our side as well, because we have the data that's available to us.

Also, education. There's more that we could be doing that to make sure that members are knowing what they have at the time of the -- of getting the prescription, and then working with their -- as you heard from Dr. Donneson, making sure that they work with their doctors. If they think that that's think gong to be 7, maybe 10, 15 days, that they're not sitting on that 7th day and now without any medication.

Because at the end of the day, we want to make sure our members have the medication that they need. So we can commit to you looking at the data, see if we're seeing that on our side, and also making sure that we can enhance communication and education through OptumRX and our providers.

COMMITTEE MEMBER TAYLOR: And I do appreciate -- and I really appreciate the fact that we've reduced the overuse and misuse of opioids. I just -- I think it's time for us to look at the other side. Because no matter what we do as human beings, it seems like, we either go

one way or the other, too far. So I do appreciate it and thank you very much.

CHAIRPERSON FECKNER: Than you.

Mr. Jones.

COMMITTEE MEMBER JONES: Yeah. Thank you, Mr. Chair.

I want to congratulate you on the prevention and educational programs that have been successful as the data suggests. I got a call from a retiree. And this question goes to the disposal process. The retiree contacted me and indicated that he'd received a document that one of the steps in the disposal process was putting it in the regular trash. So is that part of something we sent out or what's going on there? And I asked him, by the way, to send the document, so that you could see exactly what he's referring to.

MR. SHINOHARA: So our best practice is really two-fold. One is using the pharmacies or public agencies. And they have disposal stations there. And you can look that up through the California Board of Pharmacy or you can look at certain websites. And secondly is using the Deterra kit, as I mentioned here before, where you stick the medication into the bag, add warm water, and close it up, and it renders the medication inert and inactive.

COMMITTEE MEMBER JONES: So is that --

MR. SHINOHARA: There are other things that are published at the CDC, as well as California Hazardous Waste that do mention that you can use other types of disposals. But I think the best -- or better practice is really using these agencies that are disposal, specifically the pharmacies.

COMMITTEE MEMBER JONES: So it does say put it in the trash, but after you go through another step, is that what you're saying?

MR. SHINOHARA: The kits -- the kits themselves, after they're done, you can stick those into the trash, because they are --

COMMITTEE MEMBER JONES: Okay. Well, that's -- that's the part that perhaps is missing.

MR. SHINOHARA: Oh, I see.

COMMITTEE MEMBER JONES: I see. Because he was telling me that why are we putting this in the trash. Somebody could get it, you know. So I'll -- we'll -- when he provides me with information, you'll be able to respond to him and tell him what the steps are.

MR. SHINOHARA: Now, we could tell them that the kit has soluble activated carbon --

COMMITTEE MEMBER JONES: Okay.

MR. SHINOHARA: -- and makes it inert and unretrievable.

COMMITTEE MEMBER JONES: Okay. Thank you.

CHAIRPERSON FECKNER: Thank you.

Mr. Miller.

COMMITTEE MEMBER MILLER: Yeah. Thank you. And welcome, Mr. Shinohara.

MR. SHINOHARA: Thank you.

COMMITTEE MEMBER MILLER: Two kind of questions. One, I wanted to kind of follow on what Ms. Taylor was talking about. One of the things that I've heard from people, and seeing first hand, is this business of depending on what provider you're dealing with, their ability to basically re-up those prescriptions can be very different experience from provider to provider, depending on whether you have a designated primary care physician or not, and whether they happen to be there, or on the schedule when you or your pharmacy calls to get the approval, and then who's covering their file or on-call when they're not. It can be a real hassle. And it can take more than a day. And on weekends, it's all up for grabs. So that's a concern.

The other thing that really varies from provider to provider in my experience is their, I guess I would call it, approach or scope of practice when it comes to pain medicine. And a lot of them it's not pain medicine. It's just pain management. And the limit of their

practice before they will refer you, if you can even get a referal to an actual pain medication -- a pain medicine practice is cognitive behavioral therapy, acupressure, acupuncture, yoga, happy thoughts, and pharmaceuticals.

(Laughter.)

COMMITTEE MEMBER MILLER: And if you need something beyond that, if you have a chronic pain condition that doesn't have any obvious we can see it in a test, we can see it on a radiograph, we can see it on an MRI, if it's based on, you know, Rome convention syndromes -- symptoms or something, I mean, you're -- you're fighting to get a referral that then is going to cost you a bunch of money.

And so I worry that with the focus on opioids, which is well placed, that we don'e again throw the baby out with the bath water. For some of our members who really need these medications, that's -- it's the only thing that's working for them, and we don't throw up barriers. And ultimately, maybe there's some way we can really identify them and have some kind of different customized protocols for them. But that's my worry there.

The other thing I want to go back to this little disposal packet stuff, because I -- I get beat up pretty good by colleagues in the hazardous waste, and public health, and environmental health community over this issue

of CalPERS indicating to people, based on the federal requirements, that it's okay to put this stuff in the garbage, or worse yet flush it, or I even wonder whether it's okay for people to treat what's potentially hazardous waste using a methodology that doesn't prevent it from leaching out when it gets in a landfill.

And so I'm really wondering whether we have talked to, you know, the State agencies and the real advocates in the public health and environmental health community about whether this is appropriate solution for California. It certainly seems a step in the right direction versus telling them to put it in the trash or flush it.

But, you know, we're much more stringent in the state of California. We're kind of ahead of the minimum that's okay in the rest of the country. So I just hope that we'll follow up and make sure that we're heading for really optimum solutions there, as well as just this incremental improvement.

Thank you.

MR. SHINOHARA: Thank you, Mr. Miller.

CHAIRPERSON FECKNER: Thank you.

Ms. Brown.

COMMITTEE MEMBER BROWN: Thank you.

I'm not sure where we learned, before the kits

came around, we were told to dissolve them in a diaper. Dissolve the medicine in a diaper. You know, don't throw -- don't flush them down the toilet, don't put them down the sink. But I'm sure we don't do that methodology. I think the kits are great, or you can just go drop them off at Kaiser. I mean, that's great. They have a little disposal station there.

But I do want to copy on -- follow on to what Ms. Taylor and what Mr. Miller said just about having, you know, access to the drugs. I am someone who had a moderately successful back surgery in 2011, but really needed pain management. And it's -- but back then, you got a 30-day supply, and it was either percocet or hydrocodone. And then slowly you tried to wean off the drug as you -- your physical therapy increased.

And back then, you could actually call the pharmacy, and they'd call the doctor, and your prescription would be refilled. But the federal laws have changed and you cannot do that. And they try not to give you more than the 7-day prescription. And you've got to be able to get in to see your doctor. They've got to reevaluate you or they're going to send you to a pain management doctor who wants to assess how much pain you're in, in order to get a refill.

And I do want to say that what CalPERS is doing

for their members is wonderful. It turns out I was only -- I was on less than 10 MME a day for my chronic back pain, and I was seeing a pain management specialist every 60 days. But after hearing the doctor from Kaiser last July, I literally thought I need to get off this. You know, and it was very little, but still -- and so I'm very proud to say it took me several months, but I don't take anymore. Although I am in pain, but I don't have to take anymore. And it's -- I feel much better.

And I appreciate everything we do, but I think it's just educating our members that you can't just call the pharmacist and get a refill. And that if you're on it more than 7 days, which is the standard, you're going to have to go back and maybe see either your same doctor or a pain management doctor, because there are these certain time frames that they want you on the opioids, and then you need to come down and take something weaker, or you need to go back to your doctor and be reassessed.

And so I think it's wonderful what you're doing, and I think we're really ultimately saving lives by these programs. And I do appreciate you going back and looking at the data to see how many prescriptions -- refill prescriptions are being denied, and seeing if we can't help those members as well.

It's a balance, and the pendulum does swing,

right, over too much, too little, and maybe eventually we'll get it just right.

Thank you.

CHAIRPERSON FECKNER: Thank you.

Mr. Perez.

BOARD MEMBER PEREZ: When I was a young police officer, I was motorcycle officer, and I wasn't very good. I crashed a lot.

(Laughter.)

BOARD MEMBER PEREZ: So I've had -- I've had six back surgeries. And what I -- what I learned about opiates is it kind tricks your brain into saying you need more. I agree with what everyone is saying in regards to the balance. Yes, we're going to save lives, but the live -- quality of life with the people you guys are touching with this is immense. It was the worst part of my life, worst part of even the surgeries themselves was the detox. And sometimes we need to give our -- as leaders, we need to give our members what they need and not what they want. So I applaud you for making the tough decisions.

Thank you.

CHAIRPERSON FECKNER: Thank you.

Ms. Taylor.

COMMITTEE MEMBER TAYLOR: Sorry. And I forgot to

ask the question -- one of the questions I had on page five, which was as you were going through, your were talking about the number of rescue therapy prescriptions. I don't know -- I didn't catch what that was. I'm sorry.

MR. SHINOHARA: Oh, you mean, the agents that we use for treatment, the methadone, naloxone, buprenorphine?

COMMITTEE MEMBER TAYLOR: I remember rescue therapy, so that's what that is.

MR. SHINOHARA: Those are agents that we use for -- in the program -- not all of them are for rescue. Really, naloxone is the drug that we use for rescue medications.

COMMITTEE MEMBER SHINOHARA: What's the difference?

MR. SHINOHARA: The difference, the other two agents, methadone and buprenorphine, really help with some of the chemical imbalances and cravings that occur when you withdraw from opioid, and you use these other agents.

COMMITTEE MEMBER TAYLOR: Okay. So the number of rescue therapy prescriptions increased by 99 percent.

Oh, we lost you there.

MR. SHINOHARA: Yeah. So rescue medications are referring to the naloxone portion.

COMMITTEE MEMBER TAYLOR: Okay. Which is overdose thing.

MR. SHINOHARA: Overdose, right, yeah.

COMMITTEE MEMBER TAYLOR: Okay. Okay. I just want -- and the medication-assisted treatment is the other stuff.

MR. SHINOHARA: Those are the agents.

COMMITTEE MEMBER TAYLOR: Okay. That's where I didn't understand that. So, that's...

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: And just a clarification, the number increasing is a good thing, because if someone does have an overdose, this is saving lives.

COMMITTEE MEMBER TAYLOR: Oh, yeah. Absolutely.

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: So we are 100 percent trying to get the word out. And so we want prescribers under the right circumstance, if they're going to be on opioids for a period of time after a major surgery, that they have that -- that rescue therapy available for their family to be able to give to them, if they need it.

COMMITTEE MEMBER TAYLOR: Right. Right. Okay. That -- I just didn't understand what those were. Thank you very much.

CHAIRPERSON FECKNER: Thank you.

Seeing no other requests. Thank you for the presentation.

That brings us to Agenda Item 7b, Summary of Committee Direction. Ms. Bailey-Crimmins.

CHIEF HEALTH DIRECTOR BAILEY-CRIMMINS: First item that I took down was to ensure that the Title 2 reg change addresses any revisions to that section (c), so we need to make sure that there is no undue consequences by removing that.

The other was to retroactively look at our appeals data specifically around the denials, and provide the Board some information in relation to that, based on -- and then I have a lot of things that I need to get back to individuals about, but those are the two items that I took.

CHAIRPERSON FECKNER: Very good. Thank you.

Item 7c, public comment. I have one request to speak from the public, Ms. Nadine Franklin.

Please identify yourself for the record and you have up to three minutes.

MS. FRANKLIN: Okay. Is this on?

CHAIRPERSON FECKNER: It's on.

MS. FRANKLIN: Okay. My name is Nadine Franklin. I a Member Benefits Coordinator with the California School Employees Association, and have been in that position for 30 years. During that period of time, I have worked very closely with the CalPERS staff, and I want to publicly

commend them for everything that they have done over those years.

Past staff, as well as present, have done so much to educate our members and to educate me, so that I could assist our members in making sure that they have the retirement that they are entitled to.

What is unique about the classified school employees is that more than half of them do not work full time. They do not work 8 hours a day. They do not work 12 months of the year. And I learned early on in my career that that has a great impact on their retirement. And if they are not properly reported by their employer, they will receive far less money than they should have received.

The staff has helped me understand and be able to pass along to our members those unique situations, also how they can preserve their benefits, if they are leaving their school career early, or if they're transitioning into certificated positions. But unfortunately, they don't get that education so often in their schools.

So we have determined that it is up to us to help them understand what they need to be looking for, and what they need to ask for, and questions they need to ask their employers.

We have had many, many situations where people

have not been reported correctly. And because we are able to find that out, we can then let the CalPERS staff know those situations. And CalPERS takes it from there and makes sure that it's corrected.

We also -- I also coordinate our retiree unit. And it is through the retiree unit that we learned that Social Security was shortchanging our members simply, in many cases, because they were receiving CalPERS. They somehow didn't quite understand the difference between classified employees and teachers who do not contribute to Social Security, but in most cases our classified employees do.

In other cases, they had worked in positions where they weren't yet eligible to contribute to CalPERS, and that employers had chosen to have them in alternatives to Social Security. So a portion of what -- and then they purchased service credit from CalPERS, once they become a CalPERS member.

So in some cases, they are legitimately subject to a reduction under windfall elimination or government pension offset, but not on their whole pension. And that was also happening to our members. So with the assistance of CalPERS staff, when we have those situations, which are many, usually one or two a week at least that we find that have been misreported or have been reduced when they

shouldn't have been, CalPERS has always been so responsive and has set up special people for us to contact to get these matters taken care of.

Through the years, we have had pre-retirement seminars for school members only, so that they could understand those unique situations that impact them, and so they could better understand how their retirement works. We have had -- I've personally worked with every single one of the managers of the regional offices. They have been extremely responsive, always supplying us with speakers for our seminars. And because our seminars have become so large, they've had to send out two people to assist with the questions and so forth at the seminars.

Just to give you an example, this year since October, we have completed 26 seminars. Everyone of those are on Saturdays. We arrange for those, and the CalPERS staff gives of their time to come out to our Saturday seminars. They are attended from -- anywhere from 100 to 250, 300 people. And the largest attendance ever was this year in January in Modesto, 510 people came out to our school seminar.

So the staff members have just been so incredibly responsive, incredibly helpful, and so very much appreciated by myself, my colleague Deb Jachens, who is also working to help educate our members. And we, in

fact, have two former committee chairs and the current committee chair in the audience today who have continued to work with our members, and help educate them, and work closely with the staff.

And I just wanted to be sure that the Board knows how much they do for us and how much we appreciate that. So we thank you very much.

CHAIRPERSON FECKNER: Thank you. I let Ms. Franklin go a little longer on the time. First of all, she between her active status and the staff side of CSEA, she's been with CSEA for 55 years, and she's retiring the end of this month. So this was her chance to come up and say her thanks to the staff. So thank you Nadine. Thanks for all your hard work.

Ms. Lum.

(Applause.)

DEPUTY EXECUTIVE OFFICER LUM: Mr. Chair, if I could just take one moment of personal privilege here. I certainly want to also extend our thanks and appreciation to Ms. Nadine Franklin. She has been an extraordinary stakeholder that has really provided a lot of insights and clarity to the customer service teams and the uniqueness of some of the benefits and the education that's been needed by the schools and their members.

We have partnered with her and with Ms. Jachens

over the last several years. And we've seen a lot of great benefits in terms of the information and the education that the schools are receiving.

So Nadine, also on behalf of the customer service teams here at CalPERS, we want to wish you the best in your retirement, and to thank you for the education you've provided to us, and the support as well in helping to educate our members.

Thank you.

CHAIRPERSON FECKNER: Thank you.

(Applause.)

CHAIRPERSON FECKNER: Mr. Jones.

COMMITTEE MEMBER JONES: Yeah. Thank you, Mr. Chair. Ms. Franklin, I just want to also acknowledge the services that you've --

CHAIRPERSON FECKNER: Just a second, Henry.

Nadine, henry is talking to you.

(Laughter.)

COMMITTEE MEMBER JONES: I just want to acknowledge your service over the years. I became aware of the name Nadine when I was working for the school district, L.A. Unified. And I won't say how many years ago that was. But the information that she was being -- was providing then was very helpful. And after I retired, the retirees -- every time I go out to talk to retirees,

they always talk about the service that you have provided them and answers -- the questions that you've provided answers for them. And they were very appreciative.

And I just want to let you know that I also appreciate all the help you provided me. As a matter of fact, when I first elected to this Board, one of the first persons I sat down with was Nadine to get her thoughts and information that she could provide to help me do my job. So I want to thank you for that, Nadine.

CHAIRPERSON FECKNER: Very good.

(Applause.)

CHAIRPERSON FECKNER: So seeing no other requests to speak, we're at the end of our agenda. The open session is now closed. We will be going into closed session in 10 minutes, and I anticipate being able to go to the Finance Committee about 11:15.

All right. Thank you.

(Thereupon the California Public Employees' Retirement System, Board of Administration, Pension & Health Benefits Committee open session meeting adjourned at 10:15 a.m.)

C E R T I F I C A T E O F R E P O R T E R

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

That I am a disinterested person herein; that the foregoing California Public Employees' Retirement System, Board of Administration, Pension & Health Benefits Committee open session meeting was reported in shorthand by me, James F. Peters, a Certified Shorthand Reporter of the State of California;

That the said proceedings was taken before me, in shorthand writing, and was thereafter transcribed, under my direction, by computer-assisted transcription.

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

IN WITNESS WHEREOF, I have hereunto set my hand this 18th day of April, 2019.

JAMES F. PETERS, CSR
Certified Shorthand Reporter
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