MEETING

STATE OF CALIFORNIA

PUBLIC EMPLOYEES' RETIREMENT SYSTEM

BOARD OF ADMINISTRATION

OPEN SESSION

PORTOLA HOTEL AND SPA AT MONTEREY BAY

DE ANZA BALLROOM

TWO PORTOLA PLAZA

MONTEREY, CALIFORNIA

TUESDAY, JULY 18, 2023

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

APPEARANCES

BOARD MEMBERS:

Theresa Taylor, President

David Miller, Vice President

Malia Cohen

Fiona Ma, represented by Frank Ruffino

Lisa Middleton

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Jose Luis Pacheco

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Ramón Rubalcava

Yvonne Walker

Mullissa Willette

Gail Willis, PhD

STAFF:

Marcie Frost, Chief Executive Officer

Matthew Jacobs, General Counsel

Don Moulds, Phd, Chief Health Director

Rob Jarzombek, Chief, Health Plan Research & Administration

ALSO PRESENT:

Elnora Fretwell, California State Retirees

J.J. Jelincic

APPEARANCES CONTINUED

ALSO PRESENT:

Maureen Thompson, California State Retirees

Elizabeth Tyler

Larry Woodson, California State Retirees

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PROCEEDINGS

PRESIDENT TAYLOR: So we're going to start the day with an action item to approve the 2024 Health premiums for our Health Maintenance and Preferred Provider organizations. Here to present is Mr. Rob Jarzombek, Chief of Health Plan Research and Administration. Rob, welcome and thank you. Get started.

(Thereupon a slide presentation).

HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF JARZOMBEK: Good morning, everyone. Good morning, President Taylor -- President Taylor and members of the Board. Rob Jarzombek, CalPERS team member.

The 2024 HMO and PPO plan premiums are action items for your approval. The final premiums have been provided to you and are now available on our website.

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HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF JARZOMBEK: Today, I'll walk through the final weighted average premiums for next year. We'll discuss the PPOs and transitioning to one risk pool for the Basic portfolio, which is a continuation of the conversation we had in June. We'll ask for a decision on risk pooling followed by approval of the 2024, HMO and PPO plan premiums. And lastly, I'll share the next steps.

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HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF JARZOMBEK: Here are the proposed 2024 Basic plan premiums and percent changes. As a reminder, the numbers here and throughout the presentation are the State single party premiums. The regional premiums for public agencies and schools can be found in the attachments posted on the website.

Based on a discussion we had in the Pension and Health Benefits Committee last month, there was a general consensus to transition to one risk pool for all Basic plans starting in 2024. Therefore, this table shows two sets of 2024 premiums. The first set shows the premium and percentage change with a two-year phase-in. Next to it on the right are the premiums -- premiums with a three-year phase-in, which include making modest benefit design changes to the PPOs. This one is our recommendation shown in green.

There have been two changes to the premiums since you saw them in June that I'd like to highlight. The Anthem Select premium was reduced by 6.8 percent. That plan now has an overall 2.4 percent increase. This improvement was made possible as a result of a recent cost reconciliation with an in-network provider. The Anthem Traditional premium went down a half a percent. There were no other changes to the premiums since June.

J.J. JELINCIC: Can you repeat the change and speak more into the mic?

PRESIDENT TAYLOR: And a little bit slower, Rob. Sorry. It's lots of numbers.

HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF JARZOMBEK: Lots of numbers.

PRESIDENT TAYLOR: Yeah.

HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF JARZOMBEK: I agree.

So there have been two changes since we saw the premiums in June. And so the first is the Anthem Select premium. So Anthem Select went down by 6.8 percent. So the overall premium increase for that plan is 2.4 percent. So this improvement was made possible as a result of a recent cost reconciliation within an in-network provider.

The Anthem Traditional Premium went down by a half a percent. There were no other changes to any of the premiums since June. So the overall 2024 Basic weighted average premium increase is now at 10.95 percent.

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HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF JARZOMBEK: So there are no changes to the Medicare premium -- plan premiums since June. The 2024 Medicare weighted average change remains 9.55 percent.

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HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF JARZOMBEK: This slide summarizes the premium changes for the Basic and Medicare plans under each of the two scenarios. Our recommendation, again shown in the far right column in green, has an overall weighted average premium increase of 10.77 percent.

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HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF JARZOMBEK: Let's now talk about the PPO options and recommendations for risk pooling.

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HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF JARZOMBEK: As we've discussed a number of times now, without transitioning to one risk pool, the PERS Gold and PERS Platinum Basic premiums will have a 19.3 percent increase. The PPOs are experiencing continued high medical cost increases and high pharmacy costs resulting from more utilization. They also have a premium surcharge that was approved in 2022 to rebuild the reserves in the Health Care Fund. Additional surcharges are Needed for the PPOs next year. Therefore, included in the 2024 premium is an increase in the surcharge from three percent to five percent for PERS Gold and two percent to four percent for PERS Platinum.

The challenge we're facing with the PPOs is

sustainability. The 19.3 percent increase is unsustainable as we will lose a large amount of healthy members. We project a substantial migration of healthy members out of the PPOs to the HMOs later this year during open enrollment. With this migration, the gap in the risk scores between the HMOs and the PPOs would continue to widen with the PPO risk increasing significantly.

This puts more pressure on the cost and adversely impacts the Health Care Fund and our ability to replenish the reserves. The PPOs have started to become unsustainable making now the time to take action.

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HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF JARZOMBEK: This is an important visual that we presented in June. It shows that with the PPO premium increase of almost 20 percent, we anticipate that about 11 percent of members would leave during open enrollment and a majority of those members would be healthy members. Under the transition to one risk pool, the outward migration lowers significantly about to about three percent in both scenarios.

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HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF JARZOMBEK: Taking a look at the risk mix in the -- of the HMOs and PPOs, this chart shows that the difference

between them is increasing more rapidly than before. Without changes, most healthy members will leave the PPO for the HMO making the PPO premiums unaffordable for everyone.

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HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF JARZOMBEK: Now, let's look at the premium increases by scenario. A two-year phase-in to one risk pool would lower the PPO premiums by 7.7 percent to 11.6 percent. It would add 1.9 percent to the HMO premiums for an overall HMO increase of 11.1 percent. A three-year phase-in, which would include modest PPO benefit design changes would mean a 12.2 percent PPO increase and a 10.5 percent HMO increase. Either of these options is viable for lowering the PPO premium and would begin to stabilize the basic PPO. The three-year option has the advantage of lowering the HMO increase in an already difficult year by 1.2 percent rather than roughly two percent.

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HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF JARZOMBEK: Transitioning to one risk pool with a two-year phase-in would not require changes to the benefit design. However, to get the PPOs to the premium level needed to avoid the outward migration of healthy lives, the three-year phase-in requires making modest benefit design

changes. To do this, we propose to increase the cost sharing for out-of-network care from $500 to $2,000 for PERS Platinum and from $1,000 to $2,500 for PERS Gold. Making these benefit design changes would reduce both the Platinum and Gold's premiums by 1.2 percent.

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HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF JARZOMBEK: After our discussion in June, we wanted to better understand the impacts to the 5,300 PPO members who exceeded their out-of-network deductibles in 2022. Our analysis shed light in a couple key areas. First, this isn't a rural access issues. Of the 5,300 members, the average out-of-network usage for members in rural areas is about 15 percent lower than the usage we saw for members in urban areas. Therefore, members in urban areas are seeking out-of-network services at a higher rate than their rural counterparts.

Next, the most costly conditions that members seek care for, both in- and out-of-network, are virtually identical. Said another way, the out-of-network claims aren't for any type of care that's not readily available and frequently being used by others in-network. Those top three areas are cancer, hypertension, and depression.

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HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF

JARZOMBEK: Here's a summary of the premium impacts again. Under either the two-year or three-year phase-in, The PPO premiums is roughly seven percent lower. One additional advantage of the three-year phase-in is that HMO members will experience a smaller premium increase. For example, a single Kaiser member would pay about $70 less a year in premiums. And a family in Kaiser would pay about $200 less a year.

For the stability of the PPO program and the Health Care Fund, either option would adjust the PPO premium to help ensure it's a viable product in our long-term -- in our portfolio long term. In particular, PERS Gold would remain one of the lowest cost plan options available throughout the state.

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HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF JARZOMBEK: We recommend the Board approve the transition to one risk pool over a three-year phase-in while making modest PPO benefit design changes. This would stabilize the PPOs while minimizing the impact to the 2024 HMO premiums.

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HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF JARZOMBEK: For next steps, we'll ask the Board to approve either a two-year or a three-year phase-in to one risk

pool. Then the Board -- we'll ask the Board to approve the respective final premiums for 2024. Once approved, we'll begin our communication efforts. We have significant communications planned in advance of open enrollment and will encourage all members, both Basic and Medicare, to shop using our new tag line, "Shop health plans and find one that's best for you".

Each member's myCalPERS' account has a number of tools they can use to determine if their doctor is available through a more affordable plan. Members can see all the health plans available in their area, view premiums and member satisfaction ratings, compare benefits, and even make changes to their health enrollment online. For this year's open enrollment, members will be able to search Medicare doctors and Medicare plans and medical groups for -- in Basic plans.

This is in addition to the primary care physicians specialists, and behavioral health providers that are already listed in myCalPERS. In late August, we'll send letters to members and plans experiencing a nine percent or higher premium increase. These letters will include guidance on shopping for health plans. And new this year, we are including information on how much -- how much members could save by shopping and switching plans to a more affordable plan in their area.

This is in addition to the list of resources that are available for members to use to make an informed decision. The rest of the slides that follow are the basic premiums under the three-year phase-in and the Medicare plan premiums and the respective cost drivers. This concludes my presentation an I'm happy to take any questions.

PRESIDENT TAYLOR: Thank you, Rob. I do have some questions. I think Mr. Rubalcava were you first and then Mr. Pacheco?

BOARD MEMBER RUBALCAVA: Thank you, President Taylor. Thank you, Mr. Jarzombek for a great presentation. I know this in June we had quite a discussion on the need for the stabilizing the PPO and how to do it. I had -- the month since, I've had the opportunity, thanks to trustee Ms. Willette to meet with members from county of Monterey. And I understand how important an accessible, viable PPO is. And I want to make sure that we -- this Board takes whatever we can -- every action we can to make sure we have viable PPOs. It's unfortunate that the only way -- that the way to do that is to go into one risk pool where -- which will have some adverse impact on the HMO members.

However, our goal is to have a viable insurance program. And insurance, that's the way it works, where we

sort of spread the risk, and the broader risk -- the broader we can split the risk, I think it would be the best. So I would be in favor of the staff recommendation, which is to move from one -- from one risk pool to two -- sorry, from two risk pools to one risk pool over a three-year phase-in, with the modest PPO plan design changes.

PRESIDENT TAYLOR: Thank you, Mr. Rubalcava.

Mr. Pacheco.

DEPUTY EXECUTIVE OFFICER PACHECO: Yes. Thank you Mr. Jarzombek for your comments and so forth. So I'd like to, as our Chair has mentioned -- our Committee Chair, Mr. Rubalcava, I'm very disappointed that Kaiser Foundation Health Plan, you know, had -- came back -- came with these high premium rates. We had hoped that Kaiser would have collaborated with us more constructively to arrive at a -- at health rate premiums that would -- okay.

Sorry. We would have -- we would have been happier if they had come with better rates. You know, over the -- over the decades, we have -- our CalPERS members, which is about 550,000 members approximately, of the 1.5 million active members, have helped grow the market share of Kaiser in California -- in California for a long time. And many of our members, a big chunk of our members, have helped with their reserves over these years.

They've grown their market reserves. Just very disappointed in what they had -- they still came up with these high rates for us.

Regardless, I, as the Committee -- as the Committee Vice Chair, I move to approve the 2024 Health Maintenance Organ -- Health Maintenance premiums and approve the 2024-Preferred Provider Organization premiums, as well as the transition to the one risk pool over a three-year phase, while adopting the modest PPO benefit design changes.

BOARD MEMBER RUBALCAVA: I'll second.

PRESIDENT TAYLOR: Okay. So I have to take public comment before we vote on this. So we have a motion and a second to approve the rates. And before that, I have a public comment in the room, that's Mr. Jelincic. Please come up to the microphone. You have three minutes.

J.J. JELINCIC: J.J. Jelincic speaking for myself. Last year, you told Kaiser that they weren't spending enough, so you hit them with a $45 per member, per month surcharge. This year they said, okay, we'll spend more. You said not good enough, so you're going to hit with a $68 per member, per month surcharge. This Board has deliberately adopted a policy that says the high cost inefficient plans we will subsidize your business

by -- and help you grow it by subsidizing your members. And you're telling low-cost, high-control plans, we're going to punish your business by hitting your subscribers with a surcharge and using that to subsidize the high cost plans.

Now, it's even worse. You're having the HMOs subsidize the PPOs. You criticized Kaiser for coming in with a 8.16 percent increase. And you talked about how terrible that was. The PPO is coming in with an increase that's a hundred -- over 150 times that much and your reaction is, oh, we better subsidize them.

Encouraging the growth of expensive health plans is not going to lower costs. If you advocate and believe that these policies actually will lower cost, then either you're fools, your economic well-being depends on not understanding, or you're on the take.

I urge you to reject these rates. And one other thing, I want a Lamborghini for the price of a Jetta. They're both cars. In fact, they're both Volkswagen products. You're significant shareholders. You should be able to make that happen for me.

Thank you.

PRESIDENT TAYLOR: Okay. Thank you.

We have public comment on the phone for this item as well. Anybody? Susan, is that you?

SUSAN FORRER: Yes, Madam President. We have Larry Woodson from CSR regarding health rates.

PRESIDENT TAYLOR: Alright. Thank you.

SUSAN FORRER: Go ahead, Larry.

LARRY WOODSON: Yes. Can you hear me okay, MadaM Chair?

PRESIDENT TAYLOR: Yes, we can.

LARRY WOODSON: Okay. Good morning. Larry Woodson, California State Retirees. Madam Chair, members of the Board. Thank you for the opportunity to comment. I'm unable to be there in person this year, but I appreciate that this meeting is webcast and we can comment by phone.

Glad to see some downward movement in two of the plans. But it's very disappointing that Kaiser and UnitedHealthcare, in particular, are retaining their same high increases. It's just not acceptable. I would again point to UnitedHealth whose parent company UHG made $16 billion in profits last year. And their latest quarterly profits were just reported as extremely high. As I stated in my comments in June, they ought to be reducing premiums rather than increasing.

I want to shift my comments slightly to address something that will affect rates -- Medicare rates in the future, and that is the ACO REACH, which is a concern to,

as you know, CSR and many health advocacy organizations and government bodies throughout the country. And I did send all Board members, and CEO Frost, and the Health Benefits Director Moulds an email Sunday afternoon with a written report on my research and analysis of the 2023 REACH ACOs that CMS approved. There are 132 nationwide, 27 in California. That means that thousands of CalPERS retirees have been moved into REACH without their prior knowledge or consent. Medicare plans for these ACO beneficiaries are now managed by for-profit companies, many of which are PE companies and -- private equity, who as you know have the sole mission of maximizing their profits.

And I'm sure that most of you haven't had time to read my report, due to all the issues before you, but I hope that you find time to read it soon. I focused my research on the 27 California ACOs. And what I found is that shocking lack of compliance with CMS requirements. ACO website is full of outdated information and lacking transparency for beneficiaries, some not even referring to the ACO program. And most seem to designed to promote their companies to providers -- in spite of this to providers.

In spite of Liz Fowler's assurances to you that the ACO applicants were carefully screened, that does not

appear to be the case. In conclusion, if you read the report, CSR hopes that you will, at a minimum, put a topic for discussion on your next PHBC agenda to consider asking President Biden to terminate the program. It appears that Assembly Joint Resolution 4, which has passed the State Assembly and should easily pass the State Senate asking Biden to terminate the REACH Program will go forward.

Hopefully, this Board will choose to do the same.

After voting on premiums, if any of you are so inclined to move this --

PRESIDENT TAYLOR: Mr. Woodson, you are out of time. Mr. Woodson, you are out of time.

LARRY WOODSON: Okay.

PRESIDENT TAYLOR: Thank you though.

LARRY WOODSON: I hope you can agendize this. Uh-huh.

PRESIDENT TAYLOR: Thank you. Bye-bye.

LARRY WOODSON: Thank you.

PRESIDENT TAYLOR: Okay. So I have two more in the room. First is Maureen Thompson to come up and then we have -- from CSR, and then we have Elnora Fretwell from CSR as well. So Maureen, and you have three minutes.

MAUREEN THOMPSON: This is better for me. Thank you very much, Board members. I am the new Chapter President of Chapter 36. We cover Santa Cruz, San Benito,

and Monterey counties. In Monterey County, we have four hospitals, a small one in Kings City, CHOMP, Community Hospital of the Monterey Peninsula, up the hill there from where we're at, and then we have two in Salinas. Where I live in Soledad, it's 30 miles one way to my doctor's. I am very concerned about the PPOs, because even though I have Anthem Blue Cross Platinum, there's -- and I have medical insurance from my dead husband, and Medicare, it still costs a lot of money.

I am concerned that forcing us -- I've lived in this county since 1981. There's only been one HMO in Monterey County and it didn't last long. We were all required -- as I was a teacher, I was required to be part of it. So please pay attention to the PPOs, because there are a lot of people who have no other access to health care and confining us to doctors is very difficult. I've had a couple doctors retire.

Thank you very much.

PRESIDENT TAYLOR: Thank you.

Elnora.

ELNORA FRETWELL: Elnora Fretwell, executive statewide President for CSR.

Now, I'm not educated well on some of this subject, but I know the premiums are high. I don't know if -- and I hear that, you know, Jose say he don't like

what's going on. He don't like it, but he's voting for it. I don't know if you say no to Kaiser now where we end up at. I don't know if that can happen. If we say no, we don't want none of this where do our members go, who do they see? So that may be a bigger background to explore.

But I'm asking you since today you know this -- when we come up again in a couple years, maybe you start now looking for other hospitals and not doing them, and saying what's what, because I think you might be in a bind right now - I'm not sure, because I don't know - that you have to say yes to something that we don't like.

So if you can start now saying, you know, well, maybe forget you Kaiser, Unitedcare, we're going to do you anymore and do something for other hospitals that going to do best for your members, you know, right now, and do that. So I asked you to look in -- look into that for our members because this is high. I heard about the thousands, 2,000 for the PPO people. And I know that's going to -- you know, that's going to hurt them. So like I said, I don't know if you're in a bind right now and you have to say yes, because if you say no, we have no doctors nowhere to go. I'm not sure, because I don't know the process. But I'm asking you please for the next time it comes up, don't pick these hospitals. Try something -- start now trying something else better for the members.

Thank you so much.

PRESIDENT TAYLOR: Thank you, Ms. Fretwell, I agree. I do know, Rob, if you want to kind of expand on it a little bit, I -- when we're done here, I have a phone call I have to take -- just the work that went into this and why we've kind of settled where we're at. I'm not any more happy than anybody else on these rates. I just realize Yvonne is waiting to talk, so -- yeah, so it -- when -- let me take Yvonne and the phone call.

BOARD MEMBER WALKER: Rob can go and the phone call. I can wait.

PRESIDENT TAYLOR: Okay. Oh, and to Don. You want to go ahead?

CHIEF HEALTH DIRECTOR MOULDS: Yeah, I'm happy to -- you know, I think the last comment was a good comment. And this is a difficult year, as you know. There are a lot of things going on. The underlying challenge is medical inflation, which is pushing all rates higher. We have some rates that, considering the high level of medical inflation, look pretty good this year, and two rates in particular that are outliers and look very bad. And the challenge is that we have exposure -- a lot of exposure to both of those sets of rates. So one is the Kaiser rate of course. We have half of our HMO members in Kaiser and the other one is our PPO.

And part of the high rate in our PPO is the fact that we're having to work aggressively to replenish the reserves that we lost in 2021 because of the experience coming out of COVID, so that adds four and a half percent to that rate. The Kaiser rate came down a lot. We worked very hard with Kaiser to bring that rate down. It's still high. We have deep concerns about the long-term medical trend in Kaiser and will be working -- have been working and will be working with Kaiser closely to try to effect changes in the opposite direction going forward. You're going to see the high Kaiser rates not just in CalPERS, but in the rates across the state.

So it's not a good year. It's certainly not been a good year for us. These are the best rates that we -- that we could come up with. There are not improvements out there that we see in our own analysis. Remember that we do our own buildup and we do not disagree with these rates based on the medical trend that we're seeing and the pharmacy trend. We think that there's a lot of room for improvement on the medical trend.

As we've talked about in the past, we're doing much better on pharmaceutical rate trend than we have historically. We're doing better than anybody in the market. We can say that with a high level of confidence. Medical trend continues to be a challenge. So that is,

that will be a challenge not just this year, but in the future. And so it's something that we're going to need to be innovative about in our approach. We have the PPO reprocurement coming up. We're looking at a lot of novel approaches to bring down costs in the PPO. We're excited to bring them to you and to talk with the stakeholders about their implications, but we're optimistic that we have some tools to address this going forward.

PRESIDENT TAYLOR: Thank you, Mr. Moulds. I know that our staff is working really hard on our health care rates. It's difficult. We had this discussion about the one risk pool and what we have to do, but also about Kaiser. And it's tough, because most of our members are in Kaiser, so we do appreciate the work you guys do on that.

Ms. Walker, before I take the phone call. Go ahead.

BOARD MEMBER WALKER: Thank you, Madam President. So I want to say from the beginning, I appreciate all the work that has gone into this. I don't think we fully appreciate the commitment that Don, Rob, and the rest of the staff have to trying to lower rates. I will say that we have to think of, and I don't know how it's possible, but we have to think of a different way.

I would -- if it's -- if we're just negotiating

rates, we will always be in this position, so we have to figure out what are the other factors that impact health care costs and how we can best weigh in to serve the -- our constituency other than just rates -- just negotiating rates. And I would welcome that conversation trying to figure it out. I do think that the Health Benefits Committee needs to meet more regularly, because I mean it's hard to just --

(Applause).

BOARD MEMBER WALKER: -- to meet for this as we're, you know, coming on. You're always going to be in a sucky place, right? When I was President of Local 1000, we had shifted from just beating up on CalPERS when the rates came and were beating up on the health care companies, right, and we saw some movement from Kaiser. So we've got to figure this out with our stakeholder groups, right, on the -- what we're doing how we're doing it. I think it's unfair to hold our staff accountable to rates, because believe me if they had the option of coming in with single digit rates, they would be dancing in the room and slapping them on the table, and be happy for everybody that have that, but they don't necessarily have that option.

And my final thing I want to say is I don't believe $1,500 is a modest benefit design change. I think

it's a major benefit design change.

(Applause).

BOARD MEMBER WALKER: I spoke last time. I do think -- I am opposed to the motion on the table. I do think that we should go for the two-year phase-in with no benefit changes. This whole thing, whether it's two years, three years, it is -- it's a -- it is -- it's a hard decision, right? And so -- but I just think $1,500 is huge. And I don't know -- I don't feel like we -- and I appreciate the work that's gone in from the last meeting to this one to try to bring some answers, but I still haven't gotten -- I still don't feel comfortable knowing the reasons why you didn't -- even if they've gone out, why? It could be that, you know, if it's cancer -- their cancer doctor, like that might be the first doctor they went to and that's the doctor they're counting on to keep them alive, right? And they're not really con -- they're not really -- It doesn't cross their mind to think about, well, maybe I can go to somebody else and it will be cheaper, you know.

Personal story. When I was younger, my daughter had an accident, cracked her skull in three places, had to be life flighted to Children's Hospital in San Diego, right? So all of the costs that came up, right, they had to -- the paramedics came, they had to transport her to

the life flight. Life flight was not covered by insurance, so that was a cost. Checking into Children's Hospital, you had to go through the Sharp emergency room before walking down a hallway to Children's. You were charged for both. The neurologist that came was not on Children's staff, and Children's Hospital is great, because they're free, but the neurologist was from La Jolla. And when they came to tell me what they needed for my daughter, I didn't ask are you in-network, am I going to have to pay other costs? It took me seven years, seven years to pay off that medical bill.

So it's not -- it's never -- and I was employed. I was in the Marine Corps and they should have covered most of it and they didn't. So, you know, it's -- it might seem small and it might seem like we're just impacting, you know, a few people, but the impact on a few people is a major impact on them. It is not a small impact. And the impact that it's going to have on their lives is not a small impact. And for that reason, I'm opposed to the motion and I'm more in favor of the two-year phase-in with no benefit changes.

Thank you.

PRESIDENT TAYLOR: Thank you, Ms. Walker.

(Applause).

PRESIDENT TAYLOR: So I have three people on the

phone lines if we want to go ahead for the first one.

SUSAN FORRER: Yes, Madam President, we have Elizabeth Tyler calling representing herself calling regarding health rates.

PRESIDENT TAYLOR: Thank you.

ELIZABETH TYLER: Oh, thank you. Hi. My name is Elizabeth Tyler and I work for Monterey County Children's Behavioral Health.

And, you know, I guess the only comment I wanted to say, because I don't know how things work at the level at which you all are trying to operate, and I believe in the motivation of trying to get the best possible rates for your members. I believe in that. And at the same time, it's almost inconceivable to me that an organization as broad and as powerful as CalPERS is is accepting these kinds of increases. I mean, it just -- it mystifies me that there couldn't have been a stronger negotiation to get to a better offer for our membership. That's really all I wanted to say. This is going to directly impact how I live my life, how I live my life with my family. It's going to directly impact, you know, when my husband, who's a heart patient, goes to the doctor. I'm going to have to think that over, because we've got a great cardiologist and cardiothoracic surgeon, but maybe I need to change my health insurance, because these rates are just going to be

prohibitive for me and my family. So just wanted to put that out there for you all to think about.

Again, I'm proud to be a union member. I am really -- have faith in your intentionality. And the execution I feel in this instance could have been better. And I agree with the previous speaker who said maybe start working at it like right now for whatever is going to happen two or three years from now and maybe that would have a better result.

And thanks for your time and just so you know, anytime anyone asks me, hey, do you have something you want to say, it turns out I'm always going to say, yeah, I've got something to say.

Thanks for you time today.

PRESIDENT TAYLOR: Alright. So we have a motion on the table for accepting the health care rates with the one risk pool.

Oh, Go ahead, Ms. Cohen.

BOARD MEMBER COHEN: Good morning, everyone.

Mr. Moulds, you said something that kind of struck a chord with me. And I was curious if you could explain to me what drives medical inflation?

CHIEF HEALTH DIRECTOR MOULDS: So medical there -- yikes -- many things that drive medical inflation. General inflation is one of them, because when

you think about operating medical facilities, for example, energy costs have an impact on medical costs. The cost of things like materials like steel or plastic will have an effect on medical costs. So it tracks to a certain degree with general inflation, which last year ran at close to eight percent. It's coming down now.

The other major consideration is labor cost. And as general inflation comes up, increases, typically the cost of labor will increase also. There are a bunch of dynamics within medical costs that are unique to medical costs, so issues like consolidation impact medical costs. So we've seen over the last decade and a half in California that there's been significant consolidation. We have about a 30 percent spread in the difference in costs of medical care in Southern California versus Northern California. A lot of that has to do with the fact that there are many consolidated markets in Northern California as opposed to Southern California, where there are much more competitive markets. So it's really a lot of things.

It's tracked nationally. It does not track as well in California. It's sort of after the fact tracked pretty closely in California. But we're seeing -- nationally, the most recent figures I've seen in anticipation of 2024 are about seven percent. California

is going to be higher this year for a number of reasons including the Kaiser -- the Kaiser challenge.

BOARD MEMBER COHEN: Okay. Another question. I think maybe this is for you, Rob, to the staff. What are the alternatives? We reject this motion, we reject the staff recommendation, where does that leave us?

HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF JARZOMBEK: So if we were to -- if we were not to approve the rates or approve -- or not to approve one of the plan's rates, then that plan would no longer be available to CalPERS members. And so then we would have to make contingency plans on where those members would go. And so that was going to be -- they would need to go some place else to get their care.

BOARD MEMBER COHEN: And have you presented this body alternative contingency plans for us to consider?

CHIEF HEALTH DIRECTOR MOULDS: We have not.

BOARD MEMBER COHEN: And for what reason?

CHIEF HEALTH DIRECTOR MOULDS: We've -- so the contingency plans would in -- would include -- I mean, we -- basically, what you would be doing is you would be shrinking the options for CalPERS members. Conceivably, they could go find alternative care, but in many instances, they would have to leave an existing relationship with a doctor or another provider, which is

challenging to their health. So I think, you know, in our view, it is healthy for us to look at long-term which plans we're contracting with and to consider dropping plans that we think are inefficient plans. We dropped a plan in the five-year procurement, for example. But to do it in an abrupt way is hugely disruptive to people's health care and has adverse health consequences.

BOARD MEMBER COHEN: Have you studies, I guess, you know, if -- actuarials at the table, Scott, that talks about smoothing, right? Have we -- have you looked at -- or reviewed a plan or a strategy to shift us away from the more costly plans and into something that is more affordable for our members that isn't abrupt, but in a thoughtful measured manner?

CHIEF HEALTH DIRECTOR MOULDS: Yeah. Yeah, we have. So one of the things that we've done over the course of the last three or so years is increased a number of low-cost HMO options that we're aggressively leaning into: so the Trio plan, which was approved three years ago, which is a narrower network, lower cost HMO option; Western Health Advantage, which is a low-cost option in Northern California; Salud y Más, of course, in Southern California; and then UnitedHealthcare's Harmony, which is available now in Southern California and two Northern California counties. We're looking to expand it into more

Northern California counties going forward.

So we've done a couple of things. One is lean into those. And we're pushing the health plans as aggressively as we can to get them in as many counties as quickly as possible for two reasons, one is to give people a low-cost option and the other is to put price pressure on the plans that are not -- that are higher priced plans. So when they have competition, economics says that it puts pressure on them to try to be more efficient to compete, because if they don't, they lose market share. So that's one of them.

The other thing that we've done is we've added EPOs, which are HMO-like entities in the rural counties that are -- that previously had only the PPO available. So one of the downsides to the PPO product is the cost-sharing for our members is significantly higher than in the HMO. So the actuarial value of our HMOs is about 97, 98 percent. It's in the low 90s and the 80s for the PPO product, and that's because when you go to a doctor, you pay more. So the premium is not -- the premium-to-premium isn't the only comparison. The other comparison is the out-of-pocket costs. So we now have an EPO or an HMO option in every county in California as of last year, which is we think another important way for our members to have choice and in some places lower cost

choices.

BOARD MEMBER COHEN: You said aggressively leaning in to some of these alternative plans. What does that look like? I mean, are you setting it or are you -- you -- some of the rural counties. What does aggressively leaning in mean or look like?

CHIEF HEALTH DIRECTOR MOULDS: So it means the Board has approved -- the Board has approved them. Every rear in our rate negotiations, we talk about -- we ask them or in some cases insist on them expanding into additional counties. So traditionally, HMOs -- all the health plans have been very enthusiastic about going into Southern California where costs are low and margins can potentially be hire. And we've leveraged entry into those markets with a commitment to expand in the north as well.

Sorry about that.

Yeah, I'm afraid if I pull it too close, then I'm going to rip everything out of the -- but I guess I should just lean into it.

Yeah. So in our negotiations with them, we will ask them to move into areas that are harder areas. Two good examples of this in the last few years, we're bringing the Trio product into Monterey here, which is one of the low cost HMO options and we think critical for Monterey where costs are extremely high, and into Santa

Barbara, which is another area where competition is a challenge and having a low-cost HMO is really critical.

In the negotiations over the five-year contract, we were able to secure commitments to go into many Northern California counties that previously had very limited lower cost HMO options.

BOARD MEMBER COHEN: Thank you very much. And CalPERS is a big deal. And I would imagine in the marketplace, we -- the decisions that we make and the decisions that we do not make will have an -- have an impact. What has been our most significant bargaining chip in trying to get these rates reduced? What is -- what was the strategy? And again, this is may have already been presented to this body. My apologies. I just need --

CHIEF HEALTH DIRECTOR MOULDS: No. It's a good conversation to be having. CalPERS is the second largest group purchaser in America, the largest one in California, so on the -- on the commercial market. And when -- if you were to ask for sort of a single thing to point to as our advantage, it is our size. We are a very important partner for a lot of these health plans. Not being able to market products to sell their products to our members is -- sorry, did it again. There -- is a problem for them.

So it's -- so we're judicious about the health plans that we contract with, and we push them to do things that are good for our members when they -- when we do contract with them.

BOARD MEMBER COHEN: So if this plan said no Thank you, again to the motion that was being presented today, what do you think the effects would be, the ramifications in terms of the greater marketplace?

CHIEF HEALTH DIRECTOR MOULDS: So it would have a -- so --

BOARD MEMBER COHEN: Would it -- would it force Kaiser to come back, and negotiate, and say, okay --

CHIEF HEALTH DIRECTOR MOULDS: So we --

BOARD MEMBER COHEN: -- we made a mistake, we actually can lower?

CHIEF HEALTH DIRECTOR MOULDS: So we have been negotiating with Kaiser for many months now and their rates dropped from close to 16 percent as a raw rate before risk adjustment to a rate that was a little bit below 10 percent. So they came to the table. It was a tough conversation. We've had other tough conversations about the medical costs and the trajectory going forward. We are going to have another tough conversation with them next year -- and between now and next year. You know, it would have a devastating effect on Kaiser to not have

CalPERS in their portfolio. We are, I believe, their largest client it. It would devastating, in my view, for our members too.

One of the unique aspects of Kaiser is that Kaiser is the only way of getting to see Kaiser providers. And so we have families in CalPERS who have pediatricians who are Kaiser pediatricians, and primary care providers who are Kaiser primary providers. Every one of those nearly half a million CalPERS members would have to go out and find a new doctor and a new provider, health care team in the open market. It would be challenging to do that in the environment we're supply is tight and it would be disruptive to those relationships. So it's -- it is -- it is genuinely a difficult spot for both parties.

And that was part of the conversation that we had, of course, during the negotiation, but it is -- if Kaiser were to become over time too expensive for CalPERS, my strong recommend -- and we just couldn't afford Kaiser going forward, my strong recommendation would be to gradually make changes not to do something in a single year by essentially throwing them out and asking our members to go find something else.

BOARD MEMBER COHEN: So based on kind of my rough analysis -- I don't have a lot of staff around me helping me inform my decisions here, but it looks like that's the

trajectory that we're going in -- at some point, we may not be able to afford Kaiser.

CHIEF HEALTH DIRECTOR MOULDS: I will say this that, I am an optimist by nature, which some people read as naive, but I am optimistic that we can get there over time with Kaiser. Kaiser has a long track history of being an efficient provider, being a low-cost leader as well as a high-quality leader.

BOARD MEMBER COHEN: But Kaiser also has a reputation of being very difficult to work with. You think about the nurses, you think about the techs, they're constantly going on strike for better wages, more fair work schedules. So I don't know, I -- I, too, consider myself to be optimistic, but I don't know if I'm that optimistic on the direction of Kaiser.

There's been a leadership change since Bernard Tyson has passed away, and I think that that has been a loss that has injured Kaiser's overall ethos in the space that they occupy. And I think what really concerns me is that -- well, actually, the decisions that we make today, I would imagine are going to have an impact on your negotiations next year and future ones for that matter.

So how do we begin to stand up for ourselves and say, you know what, we disagree with these -- with these fee increases, recognizing that we have -- they need us

and we need them.

CHIEF HEALTH DIRECTOR MOULDS: So we have done a good amount of that in getting to where we get. I recognize that these are still extremely high rates, but we pushed back very hard on the initial rates and worked intensely with Kaiser, as I said, for many months to get to where we are, which is not as -- not where we want to be, but much better than where we --

BOARD MEMBER COHEN: Where we started off.

CHIEF HEALTH DIRECTOR MOULDS: -- where we started off.

BOARD MEMBER COHEN: But what if we started off our -- they started off the conversation negotiation artificially high with an effort to try to get us --

CHIEF HEALTH DIRECTOR MOULDS: Well, we do -- we build up our rates independently, so we -- so we do, as part of the rates process, and this is -- this is new since 2019, but we completely independently build up the rates based on -- so we have access to all the Kaiser -- all of the claims for all of our health plans, including Kaiser. And Emily Zhong, who's sitting in the front row who is our lead Health Actuary and is fabulous, works up with her team completely independently of Kaiser before we go into the negotiation where they think Kaiser should be based on a combination of past experience and future

projections about medical trends, so the inflation factors that we talked about.

Our buildup rate within CalPERS is extremely close. It's essentially identical to where Kaiser is now. As I said, we have deep concerns about the medical trend, but we do not feel like this is a rate that is -- that is excessive, given what they are actually spending. We just think that they need to be spending less.

BOARD MEMBER COHEN: Final question, have -- has a survey been conducted of our plan members that are Kaiser participants?

CHIEF HEALTH DIRECTOR MOULDS: We conduct a survey every year of all of our members and then we -- and then we break them out by plan as well.

BOARD MEMBER COHEN: And was the question asked if rates increase will you continue to stick with Kaiser?

CHIEF HEALTH DIRECTOR MOULDS: We did not ask that question. We have done -- we have partnered independently with -- with an economist at Cal named Ben Handel, who looks at price sensitivity and the prices at which people will change. And in general, CalPERS members are the term, in health policy circles, is -- are extremely sticky, which means that they tend not to leave their existing plans. Kaiser members are much more sticky than even our other members.

And the reason comes back to this issue that we talked about earlier, which is that when you leave -- if you leave -- if you go from UnitedHealthcare to Anthem, for example, you could conceivably keep exactly the same care team. So if you're in -- if you're in Sacramento at UC Davis, you can see the same group of doctors and nurses with a different health plan, so it's not a big change. If you leave Kaiser and go to United or Anthem, you have to give up those relationships. And that is a really daunting prospect for a lot of our members, and it is also, generally speaking, not good for your health. Continuity of care and an ongoing relationship with someone who knows you deeply and understands your health issues is hugely beneficial to your health.

BOARD MEMBER COHEN: Thank you very much. Thank you.

PRESIDENT TAYLOR: Great questions.

I have Ramón. I have David. I just wanted to ask a quick question myself. And I think we've asked this before, Don, we tend to focus on the insurance side to try to contain costs. Have we worked with the insurers to work on the providers, because the medical -- inflation is coming from the providers. Pharmacy inflation is coming from our benefit -- pharmacy benefit managers, right?

Once upon a time, a long time ago, before I

started on the Board, we had like three HMOs. And it seemed like costs were not well contained even then, right, because we thought we would contain them by keeping it smaller. So then we opened it up to however many we have now. All I -- I don't see how we're not including, and I know that that's not our purview, but how do we make this our purview, right, to see if we can control those costs?

CHIEF HEALTH DIRECTOR MOULDS: It's -- so it is our purview and we do do it sometimes. We do it selectively. So part of what we delegate to our health plans is our -- are those relationships and securing high quality, low cost provider contracts. There are numerous instances where we go in and micromanage for lack of a better term those relationships. We're actively having that conversation with Anthem and their relationship with some of the higher cost providers on the PPO side as we speak, because we think that is one of the tools that we need to more aggressively use to bring down PPO costs.

PRESIDENT TAYLOR: Well, one of them was I think we did take a stand on the PPOs, which was getting rid of --

CHIEF HEALTH DIRECTOR MOULDS: Yeah, we're -- we're not talking about the specifics, but, yes, we've been talking about eliminating some very high-cost

providers from the PPOs. The -- two examples of where we did that are again Monterey and Santa Barbara. So two of the highest hospital cost counties in the state, we worked with an insurer with the -- with Trio again in their entry to transition as much out of those hospitals as possible and into ambulatory sites of care, where quality is as good or better, and where costs are significantly lower. So that's another way that we put pressure on high-cost providers.

We look to move people out or provide alternative. Our reference pricing program is another great example of that, where we identify the high-quality, low-cost provider and bring cost sharing to close to zero for our members who choose to use those and expose them to more cost sharing when they go to lower quality, higher cost sites of care. So those are some of the ways that we both put pressure on those relationships. And then we do actually go in and -- in many cases, and say, no, that's not good enough. One of the challenges is that the highest cost providers are often the only providers in an area. And so this is the harm of consolidation that I alluded to when I was speaking with Ms. Cohen, that, you know, when we get down to a situation where there's a lack of competition, it's very hard to put that kind of pressure on a provider, because there is really just no

alternative for our members.

PRESIDENT TAYLOR: So -- and then, of course, we still have the out-of-state workers and retirees, but I'm more concerned about the workers that are out of state, where they only have the choice of the PPO. And I assume we continue to put pressure on the providers every year, correct, as -- to the best of our ability?

CHIEF HEALTH DIRECTOR MOULDS: We do.

PRESIDENT TAYLOR: Okay. And so we just -- I'm going to move on, so we're dealing with health care rates.

Ramón, go ahead.

BOARD MEMBER RUBALCAVA: Thank you, President Taylor. Yes, I want to commend Controller Cohen, and also the colleagues here, and the public testimony about expressing the correct questions and expressing the frustration we have over the situation on affordable and accessible rates.

I also wanted to add to Mr. Moulds' comments, CalPERS has done some innovative things, I think, since I got on the Board. One of them is very recent is where we try to narrow the scope of bargaining by ensuring that the rates were initially submitted are appropriate, meaning it's close to justified as possible. And we do that by having the -- their plan actuary for various carriers signed off -- attest that it was basically actuarially

appropriate. So there's not that big come in high, come in low. And that's why we -- we were happy to get some movement from Anthem, but the other ones where it's hard to do. So that's one thing I think.

The other one was alluded to, which is introducing narrow network, high-quality networks like Blue Shield Trio and UnitedHealthcare Harmony. Those happened very recently and I'm glad those are coming in, and I'm glad they're expanding who want to expand.

But I did often want to speak to Kaiser. And one thing that was Mr. Moulds said is Kaiser we see it as an efficient provider, which is true. And HMOs tend to be more efficient, because of managed care, and primary care physician, and they can track your progress. But I think two things has to be said here.

One is Ms. Controller Cohen alluded to it, the previous CIO for Kaiser had made a public pledge that he wanted Kaiser to be the lowest priced HMO. I don't think that's still there. But the other thing though is that we are doing different things to our PPO arena. So we're trying to add a small measure of, I don't want to say managed care, but directing people to choose a primary care physician. There's incentives to -- because we care. And that's the other thing I think is very important. We care about the outcomes, the medical outcomes, not just

choice, where people can go here and there, but outcomes where the health is coordinated.

And I think today we're going to hear some presentations about evidence, medical -- I'm not sure of the term, but health population and what's the correct evidence as to what -- how to do outcomes and how to -- how to address comorbidities with when you have somebody reporting to their doctor, but they can also indicate depression or other co-morbidities, so they can -- everything can be addressed. So I think those are some of the things that I'm proud of that -- besides the data warehouse that we talked about, that we can build up the rates on, that we're moving forward to.

It's a complex situation and I'm just glad we have the staff here that can provide some of the guidance and some of the experts outside of this room that we contract with, like whole things about what is -- what is working, what isn't, and this whole thing about this -- we're struggling with what is a right risk mitigation strategy, but I think we're getting there, because we want to reward people for the quality of care not necessarily whether they can reward them for attracting the young and invincible to don't go to the doctor, but they can make big profits on.

So I think we have to balance out the risk pools.

And I think that's something that we're doing very well. Nonetheless, there's a lot of frustration, and justifying so, because the rates are the way they are. And unfortunately, that's the system we're dealt with, where we have insurance carriers that do not necessarily provide the health. They contract with medical groups. And so the same medical groups, the same doctor may be -- will contract with more than one medical -- with more than one insurance carrier, but that's what we're dealing with, you know. So thank you. I think I spoke too much, Ms. Taylor, so thank you.

PRESIDENT TAYLOR: You know what, Mr. Rubalcava, I appreciate your knowledge and sharing that with us.

Don, really quick before I move on to David. I remember two months ago, I think, May that we had talked about cutting off new member access to Kaiser. And we decided -- I don't know if you want to talk about that a little bit. We decided against that as a cost-cutting measure.

CHIEF HEALTH DIRECTOR MOULDS: I mean, the -- so it would be less of, I think, a cost-cutting measure and more of a --

PRESIDENT TAYLOR: Punitive measure.

CHIEF HEALTH DIRECTOR MOULDS: -- punitive measure.

PRESIDENT TAYLOR: Yeah.

CHIEF HEALTH DIRECTOR MOULDS: The challenge is that -- well, there are two challenges that are significant. The first is that typically our youngest and healthiest members are our newest members. And because CalPERS members are sticky, when they choose a health plan, they tend to stay with that health plan. If we were to do that, we would have -- we would significantly change the risk pool for Kaiser, which would -- which would immediately and over time make it even more challenging for them to come back down to earth.

The other problem is that in our retention and recruitment of public agencies, many of them come to us because we offer Kaiser. And so it would -- in talking with our folks who work with the public agency community, they expressed extreme reservations about both the ability to retain public agency members and certainly to recruit any new public agency members if we were to cutoff Kaiser for new members.

So it was -- you know, it's a -- I think at the end of the day, it would be a statement, but it would have certainly detrimental effects on our Kaiser rates and on the PA side for us.

PRESIDENT TAYLOR: So ultimately, it could impact the Kaiser rates negatively is what you're saying?

CHIEF HEALTH DIRECTOR MOULDS: Negatively and -- yeah, we did not recommend it.

PRESIDENT TAYLOR: Okay. Thank you so much.

David.

VICE PRESIDENT MILLER: Yeah. I guess I'll start by saying I -- you know, I share everyone's frustration with this, but I do support staff's recommendations at this point. It's one of those kind I bite your lip and, you know, deal with the currently reality.

But I have three things I want to touch on just as ideas and thoughts. Theresa touched on one, which is curtailing somewhat going forward with new members our relationship with Kaiser. One of the things that kind of strikes me is, you know, when -- in terms of this whole price elasticity of demand kind of thing, where the prices -- and we're having outside consultants suggest to give us information on that.

I think, you know, asking our members might be a good idea, you know, at what point, but we know they're sticky. But knowing they're sticky also means putting new members into that sticky situation aside from being, you know, kind of posturing in a way. But it also, if we're trying to promote things like Trio and Harmony, would seem to be a real boon to have new people and whether it would have to be done statewide or whether it could be done on a

geographical basis, maybe that is a strategy where there are alternatives where they're going to be the sticky alternative where new people go versus Kaiser. So something, you know, a thought there.

All over the country, community hospitals have been blinking out right and left. Some of them just blink out and are gone. Communities don't like this trend. I don't know that we like this trend. But certainly other big health care organizations and private equity firms and stuff love this trend. They're buying them up like crazy. The rise of the community-based outpatient clinics starting way back in the eighties with VA demonstrated that this is a good way to deliver, especially routine health care, but it also clearly is not the best way to deliver a lot of specialty health care that's outside of the scope of practice of a lot of these kind of organizations.

And that's where PPOs can come in in a way that it's not surprising that oncology is one of the things that people go outside of network for, whether it be to a high-cost provider that we don't like, like Stanford, or, you know, Catholic Health Care West Center of Excellence for Cancer in Bakersfield, things like that, but for these -- you know, it's also not surprising that people go outside of network especially at somewhere like Kaiser for

behavioral health stuff. I mean, just anecdotally, I talk to a lot of people who have Kaiser, but who are getting their behavioral health services from someone other than Kaiser. And they're just eating the cost. They're just paying on their own.

So those kind of things also are just kind of beyond insurance kind of discussions about the quality, and cost, and performance of our health care providers. And, you know, I would suggest that perhaps if we're looking for opportunities to, A, get under the hood directly and learn more about this stuff, and B, look for alternative investment opportunities, things like community hospitals that are trying to hang on and the communities want, might be somewhere that we look at investing.

The long-term care industry is another industry like that, where the margins are low, but they're very attractive to private equity and we're interested in private equity and we're interested in those kind of services in health care where we would finally be under the hood.

So just some crazy thoughts to finish off my day.

PRESIDENT TAYLOR: Thank you, David.

Okay. Frank, go ahead.

ACTING BOARD MEMBER RUFFINO: Thank you, Madam

President. You know, since the preliminary release of these rates in June, the treasurer has received numerous comments. And you can probably guess the comments have not been positive, so to speak. And she does agree or concurs with the idea that $1,500 is not a modest increase, by the way. She does agree or concur with the -- that the $1,500 is not a modest increase. It's, in some cases a real hardship for some of our members.

But I wanted to ask, as was suggested by Director Walker a minute ago, about the two years phase-in. I would like to ask staff what would be the consequences -- or the adverse consequences of that?

CHIEF HEALTH DIRECTOR MOULDS: Yeah. That's a good question. So the two-year -- the two-year phase-in as Rob pointed out would increase HMO rates by two percent instead of 1.2 percent for 2024. The net effect on individuals with an HMO, so that's hundreds of thousands of our members would be in the range of $70 for an individual up to about $200 for a family. So that would be -- that would be an impact that would be felt by almost everybody in our HMOs. So it's -- so the -- you know, the 5,000 that Rob is talking about who hit the out-of-pocket $500 and $1,000 threshold, some subset of those 5,000 would see additional cost sharing, but all hundred -- you know hundreds of thousands of the other members will have

an additional 70 to 200 hundred dollars a year added to their health care bill.

So it's a -- it's -- you know, there is potential larger exposure to some subset of those 5,000 people, but the rest of the HMO for -- members for 2024 would see that 70 to 200 now just in the interests of going one step too far. We are talking about extending this out over three years instead of two. So if you do this in two, we are done in two, instead of three. So ultimately, it will be essentially the same number, but this is a hard year for rates and these are very high rates. And that 70 to 200 dollars is a lot to add on in a year like this.

PRESIDENT TAYLOR: Did that answer your question?

ACTING BOARD MEMBER RUFFINO: Yes. I'm trying to understand the two years or the three, that's for the future there, because that's not part of the motion.

CHIEF HEALTH DIRECTOR MOULDS: No, so that would be the direct effect in 2024 -- for 2024 rates. So if we went with the two-year phase-in, the effect on premiums, out-of-pocket costs for the hundreds of thousands of members who have an HMO, would be an additional 70 to 200 dollars.

ACTING BOARD MEMBER RUFFINO: Correct. And is that part of the motion, Mr. Chair?

PRESIDENT TAYLOR: No.

BOARD MEMBER RUBALCAVA: Well, the Chair is President Taylor, but --

PRESIDENT TAYLOR: It is not part of the motion. It's the three-year phase-in with minor modifications -- or not minor modifications.

ACTING BOARD MEMBER RUFFINO: Okay. Thank you.

PRESIDENT TAYLOR: Yeah. Thank you. Alright, Dr. Willis.

BOARD MEMBER WILLIS: Good morning. I just have a brief question. Did the current CEO, Gregory Adams, have input with the negotiation? If so, what was specified?

CHIEF HEALTH DIRECTOR MOULDS: He was -- he was not the individual we were negotiating with, but decidedly part of the negotiations. So these were all brought back to the Executive Committee at Kaiser and -- because there -- we're their largest client. It's -- you know, there were multiple consultations with them.

BOARD MEMBER WILLIS: So he was on board with it?

CHIEF HEALTH DIRECTOR MOULDS: I would -- I cannot speak for him.

(Laughter).

CHIEF HEALTH DIRECTOR MOULDS: I can speak -- I mean, he's the CEO of the organization and the organization is on board.

BOARD MEMBER WILLIS: Okay. Thank you

PRESIDENT TAYLOR: Thank you, Ms. Willis.

So I think we've got all our questions from the Board answered. We've got all our public comment and we have a motion on the table.

Christina is gone. Kayla, can we do a roll call vote, please.

Oh, where's Tuan?

Oh, there he is.

VICE PRESIDENT MILLER: A second.

PRESIDENT TAYLOR: We already had a second.

BOARD CLERK TRAN: David Miller?

VICE PRESIDENT MILLER: Aye.

BOARD CLERK TRAN: Controller Cohen.

BOARD MEMBER COHEN: No.

BOARD CLERK TRAN: Frank Ruffino?

ACTING BOARD MEMBER RUFFINO: No.

BOARD CLERK TRAN: Lisa Middleton?

BOARD MEMBER MIDDLETON: Aye.

BOARD CLERK TRAN: Eraina Ortega?

BOARD MEMBER ORTEGA: Aye.

BOARD CLERK TRAN: Jose Luis Pacheco?

BOARD MEMBER PACHECO: Aye.

BOARD CLERK TRAN: Kevin Palkki?

BOARD MEMBER PALKKI: Aye.

BOARD CLERK TRAN: Ramon Rubalcava?
BOARD MEMBER RUBALCAVA: Aye.
BOARD CLERK TRAN: Yvonne Walker?
BOARD MEMBER WALKER: No.
BOARD CLERK TRAN: Mullissa Willette?
BOARD MEMBER WILLETTE: No.
BOARD CLERK TRAN: Dr. Gail Willis?
BOARD MEMBER WILLIS: No.
PRESIDENT TAYLOR: Okay. The motion passed.
We will move on at this point. Thank you, Rob.
Let me see, where -- what time are we at.
We're a little behind.
J.J. JELINCIC: What was the vote?
PRESIDENT TAYLOR: Pardon me?
Six to five. Motion passes six to five.
I just want to move -- we're going to move on to the 2024 State annuitant contribution formulas and association plan premiums, which is kind of an actuarial mess, but my people -- my research department at my local would love to hear it. However, before we move on, I just -- I think Don explained it, but not passing the rates in July has a hugely detrimental effect. So I'm thankful that we made this, because we might have to call an emergency session if we didn't. But I don't know if I need Don to repeat why it would be hugely detrimental,

because I heard a lot of people upset that we were -- that we did pass it. So Don, if you can explain one more time what the consequences to our members are if we had not passed these rates.

CHIEF HEALTH DIRECTOR MOULDS: The consequence -- I mean, the consequences would -- are complicated, but Essentially, we have to pass rates in order for them to have health care.

PRESIDENT TAYLOR: So then the members may end up with health care rates, because we didn't pass rates, if they stayed in the same plan.

CHIEF HEALTH DIRECTOR MOULDS: These are our con -- this is our contract with our health plans for 2024 to provide health care to our million and a half members. If we do not pass the rates, they do not have access to health care.

PRESIDENT TAYLOR: They do not have -- any access to health care.

CHIEF HEALTH DIRECTOR MOULDS: Correct. If we fail to pass rates, that's correct.

PRESIDENT TAYLOR: Okay. I just wanted to make sure that people were clear on that.

Ms. Walker, go ahead.

BOARD MEMBER WALKER: Yes, Madam President. I just wanted to be clear that I was not voting against the

rates. I was voting against the plan design changes. I was not voting against merging the pools. I do believe we should merge the pools, but I felt it should be two years and not three.

(Thereupon a slide presentation).

HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF JARZOMBEK: Okay. So this is an information item, not an action item on the 2024 State employer annuitant contribution formulas and the association plan premiums.

This employer contributions for State annuitants are based on the final health plan premiums you just approved. The contribution amounts and premiums have been provided to you and are also available on our website.

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HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF JARZOMBEK: This table summarizes the State employer annuitant contribution formulas that are described in the agenda item. To calculate the contribution amounts for 100/90 Basic and Medicare formulas, as well as the 80/80 Basic formula, we use the premiums from the four largest Basic health plans.

For the 100/90 Basic and Medicare formula, the four plans with the most Basic members are Kaiser Permanente, PERS Platinum, PERS Gold and Blue Shield Access+. For the 80/80 Basic formula, the four plans with

the most Basic members are Kaiser Permanente, PERS Gold, UHC Alliance, and Blue Shield Access+.

Then to calculate the contribution amount for the 80/80 Medicare formula, we use the premiums from the four largest Medicare health plans. Those are PERS Platinum, Kaiser Senior Advantage, UHC Group Medicare Advantage, and the California Association of Highway Patrolmen Plan.

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HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF JARZOMBEK: Based on your approval of the three-year phase-in, here are the 2024 State annuitant contribution amounts by formula and plan tier. For the 100/90 Basic and Medicare formula, the single party State contribution is expected to increase by about 11 percent. For the 80/80 basic formula, the contribution is expected to increase about eight percent. And for the 80/80 Medicare formula, the contribution is expected to increase about 10 percent.

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HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF JARZOMBEK: We will skip slide 4 as it showed the amounts under a two-year phase-in.

So now to the association plans. As a reminder, CalPERS does not administer these plans and their premiums have no budgetary impact or -- budgetary or financial

impact to CalPERS. The three associations are California Association of Highway Patrolmen, or CAHP, California Correction Peace Officers Association, or CCPOA, and Peace Officer Research Association of California, or PORAC. CalPERS does not negotiate the benefit designs for these plans. Each association is responsible for ensuring that their premiums and benefit changes are appropriate and the reserve funds are adequate for their continued operations.

For next year, the only association benefit design change is with CAHP. They're increasing the number of chiropractic and acupuncture visits allowed from 20 visits per year to 30 visits per year.

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HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF JARZOMBEK: Here, we show the overall statewide weighted average premium increases. For Basic, it's nine and three-quarter percent and for Medicare it's just under six percent.

For next steps, we will continue -- we will communicate the contribution amounts and the association premiums as part of our open enrollment communications I walked through earlier.

This ends my presentation and I'm happy to take any questions

PRESIDENT TAYLOR: Thank you, Rob.

Does the Board have any questions?

It does not look like we have questions. This was an informational item. Do I have any comments on the call or any -- okay. It doesn't appear I have any comments. So, we are actually going to take a break. We ended just about on time.

(Thereupon, the California Public Employees' Retirement System, Board of Administration meeting open session adjourned at 10:32 a.m.)

CERTIFICATE OF REPORTER

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

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

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

IN WITNESS WHEREOF, I have hereunto set my hand this 24th day of July, 2023.

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