MEETING

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PUBLIC EMPLOYEES' RETIREMENT SYSTEM

BOARD OF ADMINISTRATION

PENSION & HEALTH BENEFITS COMMITTEE

OPEN SESSION

CALIFORNIA PUBLIC EMPLOYEES' RETIREMENT SYSTEM

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APPEARANCES

COMMITTEE MEMBERS:

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Kevin Palkki, Vice Chair

Malia Cohen, represented by Deborah Gallegos

David Miller

Eraina Ortega

Jose Luis Pacheco

Theresa Taylor

Yvonne Walker(Remote)

Mullissa Willette

BOARD MEMBERS:

Fiona Ma, represented by Frank Ruffino

Lisa Middleton(Remote)

Dr. Gail Willis(Remote)

STAFF:

Marcie Frost, Chief Executive Officer

Kim Malm, Deputy Executive Officer

Donald Moulds, PhD, Chief Health Director

Lisa Albers, MD, Medical Consultant II, Clinical Policy and Programs Division

Fritzie Archuleta, Deputy Chief Actuary

APPEARANCES CONTINUED

STAFF:

Rob Jarzombek, Chief, Health Plan Research & Administration

Christine Reese, Investment Director

ALSO PRESENT:

David Aguinaldo

Tim Behrens, California State Retirees

Terry Brennand, Service Employees International Union California

Mary Brown

Bobby Roy

J.J. Jelincic

Karen Speckling

John Willis

Larry Woodson

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PROCEEDINGS

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

BOARD CLERK ANDERSON: Ramón Rubcalava.

CHAIR RUBALCAVA: Present.

BOARD CLERK ANDERSON: Kevin Palkki.

VICE CHAIR PALKKI: Good morning.

BOARD CLERK ANDERSON: Malia Cohen.

David Miller.

Eraina Ortega.

COMMITTEE MEMBER ORTEGA: Here.

BOARD CLERK ANDERSON: Jose Luis Pacheco.

COMMITTEE MEMBER PACHECO: Present.

BOARD CLERK ANDERSON: Theresa Taylor.

COMMITTEE MEMBER TAYLOR: Here.

BOARD CLERK ANDERSON: Yvonne Walker.

CHAIR RUBALCAVA: I see her on the screen. Can you hear us, Yvonne?

BOARD CLERK ANDERSON: Yvonne Walker.

COMMITTEE MEMBER TAYLOR: Wave. Maybe she can wave.

COMMITTEE MEMBER WALKER: (Waved).

CHAIR RUBALCAVA: Yeah, she waved. Okay. Then

we'll take that as a present.

BOARD CLERK ANDERSON: Mullissa Willette.

COMMITTEE MEMBER WILLETTE: Here.

CHAIR RUBALCAVA: Thank you.

Now, that we've completed roll call, we will recess into closed session for items 1 through 4 from the closed session agenda. We'll reconvene in open session after we break for lunch approximately 1 o'clock.

Thank you, everybody.

(Off record: 8:31 a.m.)

(Thereupon the meeting recessed into closed session.)

(Thereupon the meeting reconvened open session.)

(On record: 12:45 p.m.)

CHAIR RUBALCAVA: Good afternoon, everybody. Welcome to the Pension and Health Benefits Committee. Okay. We're back in open session and we'll continue the remainder of the open session agenda.

Please call the roll.

BOARD CLERK ANDERSON: Ramón Rubalcava.

CHAIR RUBALCAVA: Present.

BOARD CLERK ANDERSON: Kevin Palkki.

VICE CHAIR PALKKI: Good afternoon.

BOARD CLERK ANDERSON: Debora Gallegos.

ACTING COMMITTEE MEMBER GALLEGOS: Here.
BOARD CLERK ANDERSON: David Miller.
COMMITTEE MEMBER MILLER: Here.
BOARD CLERK ANDERSON: Eraina Ortega.
COMMITTEE MEMBER ORTEGA: Here.
BOARD CLERK ANDERSON: Jose Luis Pacheco.
COMMITTEE MEMBER PACHECO: Present.
BOARD CLERK ANDERSON: Theresa Taylor.
COMMITTEE MEMBER TAYLOR: Here.
BOARD CLERK ANDERSON: Yvonne Walker.
COMMITTEE MEMBER WALKER: Here.
BOARD CLERK ANDERSON: Mullissa Willette.
COMMITTEE MEMBER WILLETTE: Here.
CHAIR RUBALCAVA: Good afternoon, Board members. because we are not all present in the same room and Board member are participating from promote locations that are no accessible to the public, Bagley-Keene requires the remote Board members to make certain disclosures about any other persons present with them during open session. Accordingly, the Board members participating remotely must each attatch[sic] either that, one, they are alone, or two, there is -- there are one or more persons present with them who are at least 18 years old and the nature of the Board member's relationship to each person.
At this time, I will ask each remote member to

verbally attest accordingly. Please conduct the roll call attestation.

BOARD CLERK ANDERSON: Yvonne Walker.

COMMITTEE MEMBER WALKER: I attest that I'm alone.

BOARD CLERK ANDERSON: Dr. Gail Willis.

BOARD MEMBER WILLIS: I attesst that I'm alone.

BOARD CLERK ANDERSON: And Lisa Middleton.

CHAIR RUBALCAVA: You're muted, Lisa.

BOARD MEMBER MIDDLETON: My apologies. I do so attest.

CHAIR RUBALCAVA: Thank you, everybody. So now we'll proceed with the agenda starting with the executive report from Don Moulds and Kim Malm.

DEPUTY EXECUTIVE OFFICER MALM: Good afternoon, Mr. Chair and members of the Pension and Benefits Health Committee[sic]. Kim Malm, CalPERS team member.

I'm going to start this morning by introducing Brad Hanson. He's been pointed as the new Division Chief over the Employer Account Management Division and replaces Renee Ostrander. In his new role, Brad will oversee all customer service and support functions to our employer partners to ensure timely, accurate, and compliant reporting. Brad has worked for CalPERS for 25 years, including the Assistant Division Chief in EAMD and in

CEOD, or our Customer Education and Outreach Division. So I'd just like to welcome Brad to the team in your new role as a Division Chief.

(Applause).

DEPUTY EXECUTIVE OFFICER MALM: He's going to have to sneak out of here soon. He's got an interview panel that he has to sit on.

But I'll move on now ot our Benefit Verification Project. As you're aware, we mailed over 8,100 letters to members on March 28th to retirees asking them to verify that they're still eligible for benefits. From those 8,100 letters, we've received responses from 91 percent of these members. There were 108 deaths reported. The average number of days since passing was 44 days. There were four that were over a year old. About half the deaths were reported in California. The remainder were spread across 15 other states.

On May 10th, we mailed over 1,600 letters to those that had not responded by the due date of April 26th. The second letter requested immediate response or their August 1st benefit payment would be held. We've performed a phone call an email campaign and have either called or emailed all those that are still outstanding. We have about a hundred that came back with undeliverable addresses.

To date, we still have not received documentation from about 700 members. The due date was yesterday. So for those that we have not heard from, we are placing their monthly benefits on hold. Again, this would impact their August 1st benefit payment.

For the 108 deaths found, we have stopped the benefit payment and began the overpayment collection process. The deaths resulted in over $1 million in overpayments, of which we've been successful in collecting over 600,000, or about 62 percent. For the remaining overpayments, we are attempting recovery from banks, sent the estate notification of the overpayment, and are researching liable parties to collect from. We've also engage FINO on the larger overpayments to assist with further collection activities, such as phone calls, additional letters, and FTB intercepts. We'll be sending legal the latest list of large overpayments where fraud is suspected.

We are looking forward to being able to utilize Socure, our death veridication vendor soon. They expect full approval from the federal government's final approval of their completed submission this summer. As a reminder, they are already StateRAMP approved.

I will continue to keep the Board updated on our efforts with this project. Moving on to other news, our

team, in coordination with Public Affairs, have produced and posted video version of our Planning Your Retirement basics class in Spanish. This was posted online on May 22nd and can be found in our CalPERS YouTube channel and also accessed through our CalPERS website. We promoted this in our PERSpective and member news email. We'll be notifying employers and asking them to share it with their teams. We've also created a QR code to video that we're using at events and in the regional offices.

As a reminder, we just had our CBEE in San Luis Obispo this last weekend. We had a total 537 attendees at the CBEE. During the event, the team helped retire three people and provided assistance to a couple of members in Spanish. Members mentioned that they were very appreciative of the Spanish video we promoted. Our next CBEE is going to be in Sacramento on July 12th and 13th.

Lastly, we'll be hosting a virtual class on Funding Your Retirement Future on June 26th and 27th. We partnered with CalHR and Social Security to present the three legged stool of retirement planning. Those that participate will learn how the CalPERS pension, Social Security, and the member's own personal savings funds will help them prepare for financially for retirement. That concludes my report, Mr. Chair and I'm happy to answer any questions.

CHAIR RUBALCAVA: Thank you. Any questions from the committee?

Seeing none, I will proceed with Ms. -- sorry. We do have a question.

Trustee Pacheco, please.

COMMITTEE MEMBER PACHECO: Yes. Thank you, Ms. Malm, for your comments.

DEPUTY EXECUTIVE OFFICER MALM: Um-hmm.

COMMITTEE MEMBER PACHECO: I'd like to just go back to the letters that you mentioned. You mentioned that there were several that were suspected of fraud. And I'm wondering what is the process? Does -- how does -- when -- if you suspect fraud in one of the -- in the collection process.

DEPUTY EXECUTIVE OFFICER MALM: It goes over to our Legal Office and the Investigations Office and they do an investigation to see like who the liable party would be. And then depending upon the ability to collect the fraud or prove the fraud, it would have to be a big enough number in order to do something about that, then the Legal Office or Investigation Office pursues that.

COMMITTEE MEMBER PACHECO: Okay.

DEPUTY EXECUTIVE OFFICER MALM: Customer Services not --

COMMITTEE MEMBER PACHECO: Okay. Very Good.

Thank you. That's all my questions, sir. Thank you.

CHAIR RUBALCAVA: Thank you.

Mr. Don Moulds.

CHIEF HEALTH DIRECTOR MOULDS: Great. Thanks. Good afternoon, Mr. Chair, and members of the Committee. We have a full afternoon ahead of us, so I'd like to keep this relatively short. We have three important topics on the agenda today, rates, our PPO solicitation, and the Long-Term Care Program. Rates were challenging this year. While our HMO rates look much more like they have in previous years, beating national benchmarks for medical inflation, we continue to see high PPO rates as we stabilize that product.

Medicare rates are also extremely high this year due to significant changes in the Inflation Reduction Act and the way CMS reimburses employer plans. Those changes are good for Medicare beneficiaries, particularly those who depend on high-cost specialty drugs, but they add significant new costs for plan sponsors like CalPERS.

We are very excited to bring you the product of our PPO solicitation, which I believe will be a model for the nation. It creates broad financial alignment between CalPERS and our new third-party administrator that will lower costs and drive quality improvement. We're also proposing adding a population health management vendor

that will help members find the right care and the right providers at the right time. If we -- it will help members with complex health conditions receive more coordinated care and achieve better outcomes as well.

The PPO proposal is notable -- is also notable for what it doesn't do. It doesn't cut benefits and it doesn't increase cost sharing. Too often, purchasers rely on those two strategies in the name of efficiency. By instead leaning into accountability and better more coordinated care, we're bucking a national trend that has been making health care less comprehensive and harder to afford.

Next, I want to call your attention to a new -- to newly published research from the National Quality Forum and Health Affairs authored by our strategic consultant Peter Lee on lives saved by improved performance on particular quality measures. The article measures the impact in lives saved and harms avoided if we improve health plan clinical performance by putting in place major financial incentives focused on a few high-value health care areas. It was inspried by the quality incentive alignment work we have been doing with Covered California and the Department of Health Care Services.

What the research shows is striking. It's

estimated that colorectal cancer and hypertension cause approximately 52,000 and 691,000 annual deaths respectively in the U.S. If health plans improved performance by reaching the 66th percentile on just these two quality measures, the same level that is now required in our HMO contract and that we're proposing today to add to our PPO contract, it would result in 34,000 fewer deaths for colorectal cancer and 110,000 fewer hypertension deaths over the next 10 years.

Translated to our own CalPERS population, this would mean roughly 600 members' lives could be saved. To me, this affirms that through thoughtful performance measurement and meaningful incentives set forth in our quality alignment measure set and alignment with our statewide purchaser partners, we can improve quality advance health equity, and ultimately save lives of thousands of Californians.

To this end, we want to let you know that CalPERS has been accepted to become a member of the National Quality Forum. This is a national community of influential stakeholders and thought leaders that help shape the future of health care quality and high standards. Our membership will allos us to continue influencing quality improvement policies and measures at the national level. We will serve on national advisory

counciles and technical expert panels, which will allow us to contribute to and learn from a national community.

That concludes my remarks. The team and I look forward to a great discussion as we dig into the important topics that we have before you today.

CHAIR RUBALCAVA: Thank you. And congratulation on your work that allowed us, CalPERS, to be invited to a national forum of that stature. Thank you.

Okay. Why don't we continue to the action consent items. I'll entertain a motion for approval.

COMMITTEE MEMBER PACHECO: I'll move.

COMMITTEE MEMBER MILLER: Second.

CHAIR RUBALCAVA: So Mr. Pacheco moves and Mr. Miller seconds.

Let's call for the vote.

BOARD CLERK ANDERSON: Kevin Palkki?

VICE CHAIR PALKKI: Aye.

BOARD CLERK ANDERSON: Deborah Gallegos?

ACTING COMMITTEE MEMBER GALLEGOS: Aye.

BOARD CLERK ANDERSON: David Miller?

COMMITTEE MEMBER MILLER: Aye.

BOARD CLERK ANDERSON: Eraina Ortega?

COMMITTEE MEMBER ORTEGA: Aye.

BOARD CLERK ANDERSON: Jose Luis Pacheco?

COMMITTEE MEMBER PACHECO: Aye.

BOARD CLERK ANDERSON: Theresa Taylor?
COMMITTEE MEMBER TAYLOR: Aye.
BOARD CLERK ANDERSON: Yvonne Walker?
COMMITTEE MEMBER WALKER: Aye.
BOARD CLERK ANDERSON: Mullissa Willette?
COMMITTEE MEMBER WILLETTE: Aye.
CHAIR RUBALCAVA: Okay. The ayes have it. Thank you.
So now, we'll proceed to item number 4, which is information consent items. I have no requests to hold anything, so we'll move on to the action item, Don and Mr. Rob.
(Thereupon a slide presentation).
HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF JARZOMBEK: Okay. Good afternoon.
CHAIR RUBALCAVA: The action item, of course, is PPO solicitation, third-party solicitation.
Thank you.
HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF JARZOMBEK: Good afternoon, Mr. Chair and members of the Committee. Rob Jarzombek CalPERS team member.
This is an action item where we are seeking your approval for the intent to award the third-party administrator and population health management vendor for the next PPO contract. As you know, we started this

journey last summer and the culmination of the team's thoughtful and hard work is here with our recommendation for the next PPO -- for the next five-year contracts.

Let's get started.

[SLIDE CHANGE]

HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF JARZOMBEK: Here is today's agenda. We will go over the timeline and objectives, share what firms participated in this very competitive solicitation, and provide our recommendation and why we are recommending those firms.

We will explain the transformative performance guarantees we are able to secure and talk through continuity and access strategies for members.

[SLIDE CHANGE]

HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF JARZOMBEK: Here's a quick look at the timeline. We have completed competitive negotiations and are pleased to share our recommendation for the intent to award the PPO contract. Once you take action, we will finalize the premiums with the firms before we approve them at the July off-site. Your approval of the intent to award the contract today will allow us to fully begin all implementation activities with the selected entities, so there will be a smooth transition going into 2025. This includes having a population health management vendor on

board to assist PPO members during open enrollment that starts in September.

[SLIDE CHANGE]

HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF JARZOMBEK: Here are the objectives we have with the solicitation. And we're happy to report we were able to meet all of them. On the financial side, we sought stability and financial alignment between CalPERS and the firms we contract with. We wanted to work with partners that can give us the lowest possible trend and total cost. And this is not just for 2025, but for over the entire five-year period of the contract, 2025 through 2029.

On the quality side, you're aware that we have dramatically raised the bar with our HMOs. Our goal is to have CalPERS PPOs be as quality and equity centered as our HMOs, so we are using the same quality alignment measure set and benchmarks that we do for the HMOs.

We are also requiring there be substantial guarantees on the part of the firms to meet those targets. Additionally, we want the health plan to work with us to achieve our goals for advanced primary care, which include integrating behavioral health into primary care, using a team-based approach to care, and ensuring referrals are made to high quality specialists.

And for the population health management

services, we want to better -- we want a way to better support our members in the PPO environment, find high value clinicians, and get the care, management, and coordination that they need. This is a gap with most PPOs, including hours, and we want to address it moving forward. That said, our members will still have the freedom to see a specialist without a referral. But for those who would like additional support, it is there for them in the form of care navigation and care management services.

We think this will help improve the member experience and also improve member outcomes. And for our most complex high needs members, such as those with multiple chronic conditions, a population health management vendor will help coordinate the care they need to achieve better outcomes.

[SLIDE CHANGE]

HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF JARZOMBEK: Because population health management services may be a new concept for many, I'd like to talk a little bit about it here. A population health management vendor is there to assist members during their entire continuum of care. Starting at the left, those services could be on the administrative side, so helping a member navigate the benefit structure or simply understanding a bill they

receive.

It also includes assisting a parent with a sick child, find urgent care options, or help a member find a provider. The population health management vendor can also assist a member looking for a therapist with whom they can identify culturally or have a similar background. Finally, as mentioned before, the population health management vendor provides complex case management for our members with serious conditions, which will help ensure their care is coordinated.

So population health management is really a wide suite of services, including providing assistance, improving the access to care for members and ensuring the care delivery that is happening is of high quality and coordinated, especially for our sickest members.

[SLIDE CHANGE]

HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF JARZOMBEK: Moving on to the firms. We received bids from two third-party administrators, Anthem Blue Cross and Blue Shield of California. We also received bids from three population health management vendors, Accolade, Included Health, and Quantum Health and Premise Health, which was a joint venture.

Each of these firms not only submitted strong original bids, but also improved them as we went through

the competitive process. This is good news as we had very strong choices representing significant improvements to -- for our members. I'd like to thank all five firms for their very strong proposals that made this solicitation very competitive.

[SLIDE CHANGE]

HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF JARZOMBEK: Today, we are pleased to present our recommendation. We recommend Blue Shield of California as the third-party administrator for our PPOs in a self-insured arrangement and a separate direct contract with Included Health to provide population health management services. While CalPERS will have two separate contracts, services will be coordinated so their delivery will be seamless to members. The advantage of having two separate contracts gives us more oversight of the services being provided, great insight into each entity's performance, and creates more accountability for the firms.

As an alternative, we have Option 2. Option 2 is to extend the current Anthem contract for one year and bring on Included Health in 2025 to provide population health management services to members. The Blue Shield third-party -- third-party administrator contract would start in 2026. This delayed start date would give Blue

Shield additional time to add more clinicians to their network with the goal of reducing member disruption.

I'll now talk through why we recommend Blue Shield and Included Health.

[SLIDE CHANGE]

HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF JARZOMBEK: So why Blue Shield? First and foremost, Blue Shield has strong strategic alignment with CalPERS. They also have total alignment on the transformative performance guarantees we have for cost and quality. We have secured significant performance guarantees with them, which we think will drive delivery system change.

As mentioned earlier, they have agreed to use the new quality measures that we added to our HMO contracts, which we help -- which will help improve outcomes for PPO members in the coming years. Additionally, their provider network structure allows to us partner on cost containment strategies as well as quality improvement efforts.

Regarding Blue Shield's networks, Blue Shield has committed to ensuring that the network continues to be sufficient and will have processes to evaluate and adjust this moving forward.

[SLIDE CHANGE]

HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF JARZOMBEK: For similar reasons, we are also recommending

Included Health. Included's -- Included Health stood out as a strategically aligned organization that is eager to partner with CalPERS. They provide best-in-class member navigation and care management services, and they were the most quality and equity focused firm in the solicitation.

Included Health also has total alignment on the transformative performance guarantees we have for cost and quality with both CalPERS and Blue Shield. They have agreed to the same set of measures and how they're held accountable to them. This is an important commitment as it demonstrates their belief that their model of care management will have meaningful impacts to our members.

For basic members, Included Health will become the point of contact for all member service functions. So the phone number on the back of the -- back of a basic member -- basic member's ID card will go to Included Health. This creates the opportunity for Included Health to help members find the care they need, including finding a high quality clinician and even scheduling an appointment for them. It also helps members find the care management services for those high cost and high use members who need the additional support, so all the things I mentioned earlier.

Also, Included Health will provide a supplemental virtual health network for both primary care and

behavioral health services. This network will serve as a bridge to help members access a clinician virtually should they be unable to schedule a timely appointment with their in-person clinician or unable to find a new primary care or behavioral health clinician.

[SLIDE CHANGE]

HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF JARZOMBEK: Before going into the performance measures, I'd to briefly explain the impacts to Medicare supplemental members, as they are different from the changes Basic members will experience with the new contracts. It's very important to note that when we talk about network changes in a couple of slides, those are for Basic members only. A Medicare supplement member's access to their providers is not changing, as the Medicare network itself is unchanged. A Medicare supplement member's access to providers is not impacted by a change of the third-party administrator.

Next, care coordination that Medicare supplement members receive to day will continue with no changes. This is because that care coordination is covered by CMS and is already being provided by clinicians for members. What is chaning for Medicare supplement members is the third-party administrator. So any administrative services our Medicare members receive today from Anthem, such as

help understanding a bill or working to have a bill paid and the Medicare member reimbursed, those would go through the new third-party administrator Blue Shield.

That said, we'd like to explore areas where additional population health management services would be appropriate, but not duplicative of what CMS currently provides. Both Blue Shield and Included Health are looking forward to working with us on this and will keep everyone informed as we continue to explore a possible partnership.

[SLIDE CHANGE]

HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF JARZOMBEK: Turning now to the performance guarantees. With this five-year contract, Blue Shield and Included Health have aligned financial objectives with CalPERS priorities and have agreed to identical contract terms.

Both Blue Shield and Included Health are putting 75 percent of their fees at risk for controlling cost and improving quality. Together, this amounts to over $464 million at risk over the five-year contract period for meeting high-bar targets, with upside potential or gain sharing if the actual trend is significantly better than projected.

The total cost of care benchmark for the first year is 5.5 percent with a target trend going down each

year to reach three percent by 2029. This three percent target is substantially lower than CalPERS current trend and aligns with the trend benchpark recently by the California Office of Health Care Affordability.

For quality, as we've mentioned previously, both Blue Shield and Included Health have agreed to using the same quality alignment measure set and benchmarks that we use in the HMO contracts. We will have the same high quality and equity standards for all Basic members regardless if they are in an HMO or a PPO. The alignment that we've been able to achieve in these arrangements and the dollars at stake for both Blue Shield and Included Health are groundbreaking.

[SLIDE CHANGE]

HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF JARZOMBEK: Let's now talk about networks, and particularly about how we're going to ensure that our members have a smooth transition for our current network to Blue Shield's.

First, for Platinum, which as you know is a very broad network. As this slide illustrates, Blue Shield's proposed Platinum network is very comparable to our Platinum network today, though with somewhat fewer primary care specialists and behavioral health clinicians. Generally, both networks cover the same hospitals,

facilities, and systems. However, this does not mean there is universal overlap. Therefore, Blue Shield will implement targeted strategies to achieve near universal overlap, which I'll walk through on the next slide.

[SLIDE CHANGE]

HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF JARZOMBEK: This slide shows the estimated member continuity in Platinum with an existing in-network provider. Our estimates of what it looks like now are on the left and the vast majority of our members who get care would have the same doctors in network. This is about 87 percent of PCPs and specialists and about 84 percent of behavior health clinicians. I'll note that not included in these numbers is the approximate 3,300 Platinum members who are not receiving any medical care. This is roughly three percent of the entire enrollment. Therefore, there's no disruption for members who have not sought medical services.

Between now and January, Blue Shield will add clinicians in the Platinum network to get to the point of near universal continuity. The goal here is to ensure our members can stay with the same clinician without doing anything. However, as you can see, this still leaves about 4,200 potential members without an existing in-network clinician starting in 2025. For this

population, we are applying the DMHC continuity of care standards that are required for HMOs to our PPOs. These provisions would allow certain members to remain with their existing clinician for up to one year. For the members who are not eligible for DMHC's continuity of care provisions, Blue Shield will provide a one-year out-of-network exception for office visits. This will allow members to continue to see their clinicians while Blue Shield -- Blue Shield can either add them to the network or Included Health can help a member find a new in-network clinician. Bottom line is that we are seeking near universal continuity for all Platinum members.

[SLIDE CHANGE]

HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF JARZOMBEK: Switching to the Gold network. Again, as with Platinum, in general, the current Gold network and Blue Shield's proposed Gold network both cover the same hospitals, facilities, and systems. However, Blue Shield's proposed Gold -- proposed Gold network is not as large as what we currently have. To address this, Blue Shield will implement targeted strategies for Gold members to ensure ongoing adeqacy and network quality for our members.

[SLIDE CHANGE]

HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF

JARZOMBEK: Right now, we estimate about 85 percent of Gold members will be able to continue to see their PCP, specialist, or behavioral health clinician in Blue Shield's proposed Gold network. Blue Shield has also committed to increasing clinicians in this network by January to achieve an approximate 90 percent continuity level for members. This leaves about 10 percent of Gold members who saw a clinician potentially disrupted, which is about 9,300 members.

However, when compared to all Gold members, not just those who saw a clinician, the percentage of disruption drops to 6.9 percent. This is because there are about three percent of Gold members, similar to the Platinum side, who are not receiving any medical care. Therefore, there's no disruption for the members who have not sought medical services.

For the Gold members who will be disrupted, here's the strategy to address continuity for them. Gold members living in 22 rural counties, which are typically areas that do not have a low-cost HMO option available, these members will have the same continuity of care and out-of-network benefits as Platinum members, meaning members who qualify for a DMHC's continuity of care provisions will go through that process, and for others, Blue Shield will provide a one-year out-of-network

exception for office visits.

This will allow members to continue to see their clinicians, while Blue Shield can either add them to the network or Included Health will help the member find a new in-network clinician. There are approximately 1,300 members in this category.

For our members in urban and suburban areas, where we typically offer a wide array of choices, if those members prefer to keep their current clinician, they can use CalPERS health plan search tool in their myCalPERS account to find which other health plans their doctor accepts. Our estimates show that about 30 percent of members could switch to a similarly or lower priced HMO to keep their current clinician, and just over 60 percent of members could switch to Platinum to keep their current clinician.

And, of course, thanks to the new population health management vendor, Included Health, all basic PPO members, whether they have continuity with a clinician or not, can obtain assistance from Included Health to help them find a new in-network clinician. This personalized support will be critically important for those members wanting to connect with a quality in-network clinician.

[SLIDE CHANGE]

HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF

JARZOMBEK: I'd like to talk now about what we propose to have in place with these new contracts that go beyond continuity and really address concerns about adequacy, access, and quality of these new networks. We recommend bringing on Included Health in September 2024 in advance of the new third-party administrator contract to help members find clinicians they need. This is important to help members confirm their clinician will still be in network the next year, and if not, help members find a new one. We think this will help improve the member experience and also improve member outcomes, as quality clinicians can better address gaps in care.

Next, we are adding supplemental virtual primary care and behavioral health services. This can serve as a safety valve to help members get the access to care they need when they need it. Yet, even as a safety valve, Included Health will have their virtual primary care program support and complement the existing primary care clinicians, if a member has them and not simply replace in-person doctors. This reflects our believe that access to in-person continuous advanced primary care is foundational to our quality and equity goals.

In the new third-party administrator contract, we have added requirements not only to ensure network quality and adequacy, but also drive our third-party administrator

to achieve higher network access and capacity standards. These requirements, which align with requirements in our HMO contracts, stipulate that all participating providers are held to quality, equity, safety, and affordability standards.

To assess network adequacy and ensure Blue Shield's networks meet our high standards for access, CalPERS will conduct independent and timely access surveys, known as secret shopper surveys. These surveys will be done on Blue Shield's behavioral and physical health networks for the duration of the contract. These surveys provide the best picture of the state of provider accessibility and accuracy of provider directories. It will give us real-time insight into what is happening on the ground and allow CalPERS to take timely steps to address it.

[SLIDE CHANGE]

HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF JARZOMBEK: Here are the pros and cons of each option. We recommend moving forward with Blue Shield and Included Health in 2025. That is Option 1. This is because we have very strong contract terms now and waiting an additional year for them to start could create an opportunity for those terms to change and become less favorable to CalPERS.

More importantly, we want to be able to deliver this product to our members now and ensure we have the total cost of care and quality guarantees in place as soon as we can.

[SLIDE CHANGE]

HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF JARZOMBEK: For the proposed next steps, with the Board's action, we will accelerate our implementation activities with the selected firms and work to finalize contracts. We will begin transition activities immediately and start the population health management contract ahead of open enrollment, so Included Health can be on board to help members make an informed decision during the open enrollment period.

The new third-party administrator contract would, of course, start on January 1st 2025. And finally, a smooth Transition for our members is central to the work we have to do in the next several months. We realize that change can be difficult and many of our PPO members have had Anthem as their PPO health plan for a very long time. For these reasons, we will work closely with Blue Shield, Included Health, and Anthem on a thorough communication plan to ensure that our members receive clear regular communications about the changes they should expect to see on how they are impacted. This includes our presentation

and we're happy to answer any questions.

CHAIR RUBALCAVA: Thank you very much for all that work land a great presentation. I will now entertain comments and questions from the trustees. We'll start with President Taylor.

COMMITTEE MEMBER TAYLOR: So I was actually putting mine on to make the motion. So I'm going to wait and let everybody talk, so --

CHAIR RUBALCAVA: Okay. Thank you. We'll have Mr. Pacheco next.

COMMITTEE MEMBER PACHECO: Yes. Thank you, Chairman Rubalcava and thank you, Rob, for your presentation. I really appreciate all that you've done as well as your team on this effort. It's been a -- it's been a long and very good material. And I just want to thank you for all the work you -- all the good work you're doing.

My first question is regarding the Included Health care -- Included Health in terms of the provision that we passed I guess back in November with the doula feature, and how that will be incorporated with respect to the Include[sic] Health and the basic -- for the basic members.

HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF JARZOMBEK: Sure. So the doula benefit that you voted on

last November to add that benefit to the 2025 plans, that will be handled by the health plans because it's a medical benefit. So with that, that will all -- it will -- that will all go on the medical side. However, Included Health will be aware of that and all of the benefit design changes, as well as just the benefit structure of the PPOs. And so they will be able to inform that member who is -- who's going through a pregnancy and may benefit from a doula. So it won't happen -- Included Health will not provide that service, but they will be connect the member with the appropriate doula to help that member through their pregnancy.

We have Dr. Lisa Albers here who can a little bit more color to that on when that is appropriate for the -- for that doula benefit to kick in.

MEDICAL CONSULTANT II ALBERS: Thanks. Good afternoon, Mr. Chairman and members of the Committee. Lisa Albers, CalPERS team member. Rob actually said it perfectly. That's how it will work. Included Health will be made aware of the benefit and we'll be able to direct members -- pregnant members, who are in need of doula services, to the appropriate doula provider, either with -- working with the TPA, the third-party administrator, or simply because they have that direct contact with the doula providers. We have also instructed

our health plans to outreach to members who are at higher risk of pregnancy complications, perhaps because of their race and ethnicity, and so Included Health will be aware of this information as well and will be expected to also make those members aware of this benefit.

COMMITTEE MEMBER PACHECO: And with respect to the identifying of members, members that have, like for instance, gestational diabetes or eclampsia, issues of those natures, the high-risk pregnancies.

MEDICAL CONSULTANT II ALBERS: Yes. Part of what Included Health will do as the population health management vendor, is that they will look at each of the members. They will look at claims information, medical and pharmacy claims, they will look at electronic health records, they will look at standard assessments, and then they will determine if there are members, including pregnant members, that are in need of additional support services or additional care management services. Additionally, members can always reach out to the population health management vendor on their own looking for those services or providers can refer them as well. So there are multiple ways to identify members who might be in need of additional services.

COMMITTEE MEMBER PACHECO: But the Include[sic] Health would be basically kind of navigating the process,

is that's my -- that's my -- I'm trying -- that's my understanding.

MEDICAL CONSULTANT II ALBERS: Yes. I'm sorry. That's absolutely true. They will be the prime navigator, if you will, to direct the member to the appropriate services.

COMMITTEE MEMBER PACHECO: Okay. Very good. And my last question is if we do approve this, what is the timeline and communication communicating out all this information.

HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF JARZOMBEK: So for communications, what we are going to -- we, will -- we, CalPERS, will send our own letters to members. This is part of our standard process we've had for several years now informing members in advance of open enrollment about significant changes happening, whether it's the removal of a health plan or significant premium changes. This would definitely be part of what we want to communicate to them, the change in the -- potential change in the third-party administrator and the addition of a population health management vendor.

Blue Shield and Included Health will also perform some outreach activities to members informing them of the change and the switch. And so members will receive multiple communications from -- meaning each -- at least

one from all three of us to ensure they are aware of the -- of the change. We're also committed to providing additional outreach to members. As part of our open enrollment process, we do webinars, we do articles for retiree stakeholder groups, or any labor organization's group. There's a lot of things that we have available to us and we'll be -- and we've heard some suggestions already today about other things that might be helpful for employers to understand it, and for members to understand what is changing and what isn't changing. So we'll definitely have a very strong communication plan in place, so that members are informed of what's -- what is changing as they go into open enrollment, so they can then make an informed decision during that time frame, which is mid-September through mid-October.

COMMITTEE MEMBER PACHECO: And this will be -- the communication will be from both sides, not only from CalPERS, but also from the plans themselves.

HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF JARZOMBEK: It will be from all three entities, CalPERS, Blue Shield, and Included Health, yes.

COMMITTEE MEMBER PACHECO: Okay. Very good then. That's all my questions. Thank you, Chairman.

CHAIR RUBALCAVA: Thank you, Mr. Pacheco.

Now, we'll go to Mr. Miller and then we'll go to

Ms. Yvonne Walker afterwards.

COMMITTEE MEMBER MILLER: Yeah, thank you. I just -- I want to really acknowledge and appreciate all the work that's gone into this by our -- by yourselves and the team. I realize just what a phenomenal scope of this undertaking and all the efforts. I also want to appreciate all the input from our various stakeholders, members, employer, everyone. It all helped. And I think the proposal that's before us, to me, is very encouraging. It's groundbreaking. I think it establishes kind of a whole new way of going forward in terms of addressing performance, costs, accessibility, the accountability factor, sharing in that accountability, and kind of a new day hopefully for us and for our members. And I -- it really -- it hits all of the issues that we have raised. It hits the needs and expectations of our members and what they deserve, and I think I'm just very encouraged by it and pretty confident we're going the right direction with this.

And I just want to thank you and staff for putting this together in a way that I can feel comfortable that I understand it, that I'm confident in what we're trying to achieve, and more importantly confident that we are going to deliver for our members with this particular recommendation. So thank you.

CHAIR RUBALCAVA: Thank you, Trustee Miller.

HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF JARZOMBEK: Thank you very much.

CHAIR RUBALCAVA: Now, we'll go to Trustee -- Ms. Walker.

COMMITTEE MEMBER WALKER: Thank you, Mr. Chair. And I want to echo my colleagues remmarks on the outstanding job I think that you have done on this. I mean, when it was presented I was like, wow, it was an absolute lot. I think it will be a benefit overall to our members.

So I just have a few questions and things I want to say. So one any time you go through a transition, right, and there's going to be impacts on people, I believe that as we're looking at the continuity of care, and I appreciate that the Health -- I can't remember their name. Sorry. I wrote it down, but at any rate. So I know that they going to be reaching out to everybody else, but I want to make sure that the Board is getting updates on what's happening, what's going on, and everything else as we go on, especially as it relates to the continuity transition.

And then I also wanted to appreciate the fact that we're going to do an early start on Included Health. That was the one I was looking for. Sorry. That we're

going to do an early start on Included Health, I think that's going to be etremely important, and then also wanting to make sure that -- and I'm sure they are already, but to make sure that as we go through this process, the call center -- the CalPERS call center is, you know, we've provided additional staff training or whatever, to make sure for when the calls come in that they can be handled as expeditiously as possible.

And also, the last thing I want to say is I am a firm believer in when you're doing things like this and overcommunicating, so -- and I know that, you know, we have processes that have been -- gone -- done throughout the past, but I'd like to recommend as we look forward to do -- you know, I know that we do the stakeholder meetings and we do retiree meetings, but maybe wanting to ramp them up a little bit as we go through, because I know for a lot of the retirees they'll talk to their organizations first. And we want to make sure that their organzations are in the best way to help, and that we're all saying the same thing, and being on the same page, and making sure that our constituents are being helped as much as possible.

So I think that that's it, other than to just once again say I think you guys have done a very good job on this.

CHAIR RUBALCAVA: Thank you, Ms. -- Trustee

Walker. Don, I think we should take that as Board direction to make sure there's reports to the Board on continuity of health -- continuity of the care as we go through the --

CHIEF HEALTH DIRECTOR MOULDS: Absolutely, yeah.

CHAIR RUBALCAVA: Thank you.

CHIEF HEALTH DIRECTOR MOULDS: I think that's important and something we're committed to.

CHAIR RUBALCAVA: Thank you. Next, we'll have Mr. Palkki -- Trustee Palkki.

VICE CHAIR PALKKI: Thank you, Chair. I'm not going to repeat anybody. I think what was said has already been said. I do want to just add one little caveat though. When we do reach out to communicate with the members that we add some communication to our Spanish speaking members. I know that we started that and I want us to continue that. And any way we can support individuals that speak a language other than English, that we make them feel comfortable as well too. So thank you.

CHAIR RUBALCAVA: Thank you, Mr. Palkki. And then we have Mr. Frank Ruffino for Trustee Ma, Treasurer Ma.

ACTING BOARD MEMBER RUFFINO: Thank you. Thank you, Mr. Chair. And thank you again. You know, I just want to echo the comments already made by the rest of the

members. Treasurer Ma really reappreciates Rob, Don, and the entire Health Benefits team, all your incredible work on this.

That said, you addressed it in your presentation a little bit regarding the transition to Blue Shield of California and Included Health. And I believe Mr. Pacheco and even Yvonne sort of touched on this a bit. But would you be -- can you elaborate a bit more on the specific steps and perhaps timeline for the transition activity just to ensure that members experience the very minimal disruption, especially those who have been with Anthem for a very long time. It would be helpful. Thank you.

HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF JARZOMBEK: Sure. So one of the things that we're recommending is in the recommendation that's in the Board materials within the agenda item is to bring Included Health on board, so they can be ready to go to help members during open enrollment. And so this is something that was -- we realized was very important, because we want to make sure members can make that informed decision during open enrollment about what clinicians are still available in the network. As we talk about, there is a very high level of overlap between the current network and the proposed networks moving forward. And so we want to make sure members are confident, knowing that they can

stay in the PPOs and still have access to the clinicians that they have a relationship with or that their family has a relationship with.

So the timeline of that is to bring Included Health on board before open enrollment. And so that is where that will happen and that will be the first time where members will be able to contact Included Health to actually work through their open enrollment issues -- not issues. I should say work through the questions they may have to get validation that they're in -- that their provide will be in-network, or work to help them find a new in-network clinician for 2025. And so that portion will happen in the August time -- August and September time frame. Open enrollment begins on September 16th and goes through October 11th or so. And so we need to make sure that that Included Health contract is in place and that they're on board then.

And so that is where the -- where the member service aspect and the population health management services will be ver important this year before we even get to the new third-party administrator start date of 1-1-25.

ACTING BOARD MEMBER RUFFINO: Excellent. Thank you and thank you, Mr. Chair.

CHIEF HEALTH DIRECTOR MOULDS: You know, I'll

also just add that this is something that Included does. So they, in some instances, have worked with employers solely for the purposes of transitioning from one PPO to another PPO. So they have -- I mean, all of the population health services that we've talked about are why we brought them on, but this is also a really important role and it's something that they have direct experience and a long history of doing.

CHAIR RUBALCAVA: Okay. No more questions from the Committee. So I think we'll call on public comment for this item. And we have Terry Brennand.

I like your T-shirt.

TERRY BRENNAND: Yeah, I was at the rally today.

(Laughter).

TERRY BRENNAND: Good afternoon, Mr. Chair and Trustees. Terry Brennand on behalf of SEIU California.

While I'm loathe to pile on all the accolades for Don and Rob, they did a fantastic job. Their team -- this was a very complex, complicated, hard time to have these negotiations and I think the end result is something that hopefully will be transformative for our members in receiving health care through CalPERS. There are so many of our members that don't have access to an HMO, do not have access to anything other than the PPO, and we needed the change we're seeing in these proposals.

I do want to make one admonition, based on our past experience in this field, and I guess as sort of a warning to the new provider should you choose, it's that when they get into tough negotiations with a provider, they've often threatened to cancel the contract, actually canceled some contracts, sent letters out to our members to engage them and put the pressure on it. It would be much more effective if they came to us, came to CalPERS. You'll be shocked to know unions have a little bit of experience in negotiating and treating us like a partner instead of driving fear would be a much more effective way to get results, when we're trying to lean on a provider that's not acting appropriately, not negotiating in good faith and the like.

So we hope, if it's Shield, that when we go into the future, that will be their approach to tough negotiations. Lean on your partners, don't threaten them.

With that, we support the staff recommendation and look forward to your adoption. Thank you.

CHAIR RUBALCAVA: Thank you, Mr. Brennand.

With that, I'll call on Ms. -- President Taylor. I'll entertain your motion.

COMMITTEE MEMBER TAYLOR: Thank you, Chair Rubalcava. So I move to approve the staff recommendation to accept our Option number 1, Blue Shield and Included,

and implement them -- part two, implement them starting for the 2025 year.

COMMITTEE MEMBER MILLER: Second.

CHAIR RUBALCAVA: Second by Mr. Miller. now, we'll have the vote. The roll call, please.

BOARD CLERK ANDERSON: Kevin Palkki?

VICE CHAIR PALKKI: Aye.

BOARD CLERK ANDERSON: Debora Gallegos?

ACTING COMMITTEE MEMBER GALLEGOS: Aye.

BOARD CLERK ANDERSON: David Miller?

COMMITTEE MEMBER MILLER: Aye.

BOARD CLERK ANDERSON: Eraina Ortega?

COMMITTEE MEMBER ORTEGA: Aye.

BOARD CLERK ANDERSON: Jose Luis Pacheco?

COMMITTEE MEMBER PACHECO: Aye.

BOARD CLERK ANDERSON: Theresa Taylor?

COMMITTEE MEMBER TAYLOR: Aye.

BOARD CLERK ANDERSON: Yvonne Walker?

COMMITTEE MEMBER WALKER: Aye.

BOARD CLERK ANDERSON: Mullissa Willette?

COMMITTEE MEMBER WILLETTE: Yes.

CHIEF HEALTH DIRECTOR MOULDS: Mr, Chair, if it's okay, I think the other piece of this that we're proposing is that we start the Included contract prior to 2025.

CHAIR RUBALCAVA: Right. September.

CHIEF HEALTH DIRECTOR MOULDS: If we could get your vote on that, that would be --

HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF JARZOMBEK: And so that was the --

CHAIR RUBALCAVA: Can you amend your --

COMMITTEE MEMBER TAYLOR: So I can just amend it to start the Included contract.

HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF JARZOMBEK: And it's actually what is written in the agenda item. So you just want to approve the recommendation of the agenda item, that will cover everything nicely.

COMMITTEE MEMBER TAYLOR: Okay. So we're amending that to --

CHAIR RUBALCAVA: So that will be our -- that would be our call then.

COMMITTEE MEMBER TAYLOR: Yeah.

CHAIR RUBALCAVA: That is our -- thank you.

I also want to take this moment to thank Don and the staff for all the work you've done on the PPO. I know it's amazing undertaking, but I think the goal to elevate how we handle PPO to bring in some quality measures that we already have in the HMO to the PPO will be great. Also, the whole aspect of differentiating the Gold PPO, so it can be seen as a quality network, that was to maybe a

little bit smaller. I think that's -- the results we'll see it in the lives saved, the quality outcomes for our patients, and our members. So I thank you for all that work you've done -- you and your staff have done.

CHIEF HEALTH DIRECTOR MOULDS: And thanks. And, Mr. Rubalcava, if I could have a moment of personal privilege.

CHAIR RUBALCAVA: Please.

CHIEF HEALTH DIRECTOR MOULDS: I wanted to thank a few folks. One is our partners at Anthem.

CHAIR RUBALCAVA: Yes, of course.

CHIEF HEALTH DIRECTOR MOULDS: So they've been our PPO partner for a long time now. They really -- they really put a lot of effort into their solicitation. When Rob says this was a competitive solicitation, it was a competitive solicitation. They -- both insurers are well out of their comfort zones in these negotiations. And we appreciated it coming from both of them. And especially to Anthem, they were very disappointed when we told them what our recommendation would be to the Board, but they have signaled early that they would be helpful partners in the transition and they have, to date, made good on all of that. They've been great at being responsive about the need that we're going to have now to start sharing data on our PPO members with Blue Shield and in all of the work

that we need to do to make sure that this is as seamless as possible. So I want to thank them for that.

I also want to thank there -- and this list is somewhat long. I apologize, but I don't really apologize. I want to thank the team members who put a lot of time into this. There were a lot long hours and more weekends than I would acknowledge in front of Mr. Brennand, Brenda Yee, Juliet Lac, Lisa Albers, Kellye Smith, Emily Zhong, Hilary Kyumba, Julia Logan, Rob, Kristen Owens, Ryan Yamadera, and David Van der Griff from CalPERS. And then we had three consultants that we spent a lot of time with. Peter Lee, who you've heard from a few times, but also Barb Dewey, and Coleen Young. Barb, a couple of years ago, moved back to Vermont. And so had many calls where her kids would bring dinner into her as we were on calls working through this, and a few sad ones where they would come in and say good night, but we deeply appreciate their efforts and their support on this project as well. So thank you.

CHAIR RUBALCAVA: No, that's very appropriate to recognize staff, because this was quite an undertaking.

COMMITTEE MEMBER TAYLOR: I'm being told that we were clear, so I have to redo that motion.

CHAIR RUBALCAVA: Okay. Before we do that, please, Ms. President, we have a caller on the line, so

let's hear from our public first and then we'll retake the motion and the vote.

So the caller, are you there?

Hello.

Do we have a caller on?

DAVID AGUINALDO: Hello.

CHAIR RUBALCAVA: Hell. Please proceed.

DAVID AGUINALDO: Oh, wonderful. Thank you.

Hi, everyone. My name is David Aguinaldo. I am an auditor with the CDTFA. I work out of state. And so I just wanted to come on for this agenda item and just -- obviously, this choice between these two potential PPO providers is going to weigh heavily on our members and out of state, as all of us have only one choice, and which is the PERS Platinum -- PERS Platinum plan.

So, I know that you all spoke a little bit about some of the network changes that might be happening. I just -- and how, you know, while most things will overlap, some things won't. I was just curious if those statistics that you provided were speaking directly about California or about the entire network across the entire country, and if special attention was given to make sure --

COMMITTEE MEMBER TAYLOR: Is this David?

DAVID AGUINALDO: -- just because we have people living in so many different states with so many -- with

such a different range of health care providers, I am concerned that maybe an outsized number of those, you know, issues of providers not being, you know, continuous may fall on out-of-state members. I didn't really hear anything addressing that. So that was just something I wanted to check in on.

The other thing that was also interesting -- well, I'll get to that later. So, yes, I'll just start with there -- was there consideration for those out-on-state members that rely on this PPO Platinum plan to make sure that, you know, we're not going to be disproportionately affected by this.

CHAIR RUBALCAVA: Thank you for your call and we do have an answer for you.

HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF JARZOMBEK: So yes. So thank you for that question. So for our out-of-state members, there will be no change to network. So both Anthem Blue Cross and Blue Shield of -- Blue Shield use the same out-of-state network. They're part of the Blues family and so it will be the same network that our out-of-state members have today will be the network that is going to be in place for 2025.

DAVID AGUINALDO: Okay. That's great. Thank you very much for your answer.

CHAIR RUBALCAVA: Okay. Now, we understand we

need to retake the motion, so --

COMMITTEE MEMBER TAYLOR: Yeah. So I'm going to read it, because it does have specifics in it.

Approve the recommendation of an intent to award a five-year -- five-year contracts to Blue Shield of California as the third-party administration -- administrator and Included Health as the population health management vendor for CalPERS PPO plans with an effective date of January 1, 2025. Awards are subject to the final negotiations and satisfaction of all requirements, including, but not limited to, implementation activities occurring in 2024.

COMMITTEE MEMBER MILLER: (Hand raised).

CHAIR RUBALCAVA: So, Mr. Miller -- Trustee Miller seconds. And now, we'll call the vote again.

BOARD CLERK ANDERSON: Kevin Palkki?

VICE CHAIR PALKKI: Aye.

BOARD CLERK ANDERSON: Deborah Gallegos?

ACTING COMMITTEE MEMBER GALLEGOS: Aye.

BOARD CLERK ANDERSON: David Miller?

COMMITTEE MEMBER MILLER: Aye.

BOARD CLERK ANDERSON: Eraina Ortega?

COMMITTEE MEMBER ORTEGA: Aye.

BOARD CLERK ANDERSON: Jose Luis Pacheco?

COMMITTEE MEMBER PACHECO: Aye.

BOARD CLERK ANDERSON: Theresa Taylor?
COMMITTEE MEMBER TAYLOR: Aye.
BOARD CLERK ANDERSON: Yvonne Walker?
COMMITTEE MEMBER WALKER: Aye.
BOARD CLERK ANDERSON: Mullissa Willette?
COMMITTEE MEMBER WILLETTE: Yes.
CHAIR RUBALCAVA: Okay. The ayes have it, motion passes. There's no abstentions or no -- nobody vote -- the Committee voted.
I, too, want to thank Anthem for their service on the TPA services and look forward working with -- to staff, CalPERS -- working with CalPERS staff on the transition. Thank you.
So now, we'll move on to the next item, which is Informational Item number 6a, the 2025 HMO and PPO plan premiums. Don Moulds and Rob.
(Thereupon a slide presentation).
HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF JARZOMBEK: Okay. Good afternoon again, Mr. Chair and members of the Committee. This is an information item to update you on the preliminary 2025 rates for the Basic HMO and Medicare Advantage plans. I will also share how the rates for the Basic PPO, Medicare -- Basic PPO and Medicare Supplement plans correspond with the new third-party administrator and population health management

vendor contracts we just discussed.

[SLIDE CHANGE]

HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF JARZOMBEK: Here is our agenda. We'll begin with the timeline for this rate development process. We'll provide a quick refresher on how we set premiums, go over influencers and trends for 2025, and talk about our transition to a single risk pool and the impacts it has on the HMO and PPO plans. We will then walk through each plan's preliminary premium and the factors impacting it.

[SLIDE CHANGE]

HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF JARZOMBEK: I'll start with a timeline. In November, you approved service area expansions and benefit design changes for the 2025 plan year. This included service area changes and adding the doula -- the travel and doula benefits to our program. These changes are incorporated into the premiums you'll see today.

In May, we presented the initial premiums for all plans to you in closed session. And today is the first time we are presenting the preliminary premiums to you in open session and to the public. Then in July, we'll present the proposed final premiums for your adoption at the Board off-site.

[SLIDE CHANGE]

HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF JARZOMBEK: As a refresher, I'll go over what makes up a premium and the process we use to determine what the premiums should be. The premiums can be broken down into three components, medical, pharmacy, and administration.

Medical is the cost of medical services provided. This includes inpatient, outpatient, and other professional services.

Pharmacy represents the cost of outpatient prescription drugs filled at a local pharmacy or through mail order.

Administration is the health plan's administrative fee and CalPERS administrative expenses.

To get the per member, per month rate, or PMPM rate, we add the medical, pharmacy, and admission -- administration components together. Once we have that rate, we convert it to a premium by applying a family factor that takes into account the number of dependents in each health plan. We apply a family factor, because young dependents typically incur lower medical costs than adults. This changes the PMPM rate to a per subscriber per month or PSPM premium. This is the premium amount that is presented publicly and charged to members and employers.

A few years ago, we greatly improved how we set

health premiums to enhance transparency with each plan's proposed rate and improved our negotiating position. We use claims in the data warehouse along with financial information to create a baseline projection for each plan. We then compare it to the plan's proposed rate. We require the plans to submit their proposal in specific categories using a standard methodology, so that we can conduct an apples-to-apples comparison to our projections. We also require them to submit an actuarial attestation of their proposals. Further, we engage an independent actuarial consulting firm to conduct a third-party verification and review.

Our approach using standardized methodology allows CalPERS to drill into significantly more detail with the plans to understand what's driving trends at the plan level.

Finally, we risk adjust premiums for the basic plans. We do not risk adjust the Medicare plans as this is done by CMS through their own process. Risk adjustment of the Basic plans allows us to price plans based on the value of their Benefit design and network, rather than on the concentration of healthy or unhealthy lives in the plan. This pushes the plans to compete on the cost and quality of care, instead of on their ability to attract younger and healthier members.

As you know, last year, the Board approved the transition from two risk pools, one for HMOs and one for PPOs, to a single risk pool for all Basic plans. With 2024's premiums, we took one-third of the step towards a single risk pool. This was done to stabilize the PPO.

The last item on this slide is how we set premiums for public agencies and schools, as there is an extra step to that process. We start with the State premium calculated for State of California and CSU members. Despite the fact that there are State employees in every county, the State as an employer uses the same pay scale, classifications, and benefit structure for everyone. Therefore, they use the same premiums regardless where State employees reside.

We have three pricing regions for our contracting agencies, one in Northern California and two other regions in Southern California. We included the preliminary premiums for these regions in the attachments to this presentation.

[SLIDE CHANGE]

HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF JARZOMBEK: On the Basic side, medical inflation and pharmacy costs are always the two big drivers of premium increases. In the 2025 submissions, we are seeing a pretty good medical inflation trend that is slightly lower

than national benchmarks. The story is not positive, however, for pharmacy costs. In 2023, we saw higher than anticipated pharmacy spend and this trend is expected to continue in '24 and '25.

In fact, you will see that pharmacy costs contribute to a material portion of the 2025 premium increases for most of the plans that we'll -- that I'll share later. Although or Optum contract has competitive pricing, the increase use of high cost brand and specialty drugs contributed to the total pharmacy spend going up by double digits. This is driven by changing guidelines for common diseases like diabetes and the increased use of pharmaceuticals for chronic conditions.

For Medicare plans, both medical and pharmacy are major contributors to premiums with the same issues that caused them to be drives on the Basic side applying to the Medicare plans too. Additionally, due to the Inflation Reduction Act, the amount of money the federal government contributes is also a factor. This creates additional costs for plans and purchasers and uncertainties in projecting pharmacy costs in the Medicare plans for 2025. We will talk more about this later in the Medicare section.

[SLIDE CHANGE]

HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF

JARZOMBEK: Before going into premiums, I would like to discuss our recommendation for making the full transition to a single risk pool in 2025 for the Basic portfolio. As you certainly remember, last year, you voted to transition from two distinct risk pools, one for the HMO plans and one for the PPO plans, to a single risk pool in our risk adjustment process for all Basic plans. You did this because the previous structure was contributing to the instability of PPO premiums and was ultimately unsustainable.

When you voted to do this, you also voted to do it over three years with 1.3 percent premium impact to the HMOs each year. This was done in part because last year, we were facing very high HMO rates, so adding to them was going to be particularly tough on our HMO members and especially on our over 500,000 Kaiser members. Currently, we are slated to take the second step of the three steps towards a single risk pool in 2025 and the final step in '26.

The HMO premiums -- premium increases are much improved this year compared to last year, but we continue to worry about the stability of the PPO and recommend fully transitioning to a single risk pool next year. Here are the key factors influencing our recommendation.

The Basic PPOs continue to experience high

medical and pharmacy costs. The overall medical cost in 2023 increased by a double digit trend from 2022, and as a result, the funded status of the Health Care Fund continues to worsen. Despite having the surcharge that was expected to accrue approximately $110 million this year, our updated projection shows that the funded status of the HCF is not going to improve at all. In fact, we are currently projecting to lose approximately $17 million this year, largely due to unanticipated increases in the utilization of high cost specialty and brand name drugs.

Because the HCF is in such a serious situation, yesterday in the Investment Committee, the team recommended changing its investment allocation from bonds to a hundred percent short-term cash equivalent assets. This is recommending to protect against principal losses and ensure cash is available in case it is needed to pay claims. For a fund of this nature, it is highly unusual to have a hundred percent liquidity.

At this point, maintaining a stable population in the PPO program is a key factor in replenishing the needed reserves in the HCF. Therefore, the sooner the transition to one risk pool, the quicker we can stabilize the Basic program by minimizing member migration from the PPOs to the HMOs.

The final factor I'll note is that with a full

transition to a single risk pool in '25, the path is quickened to having single digit premium increases for the PPOs in future years. This is because more members would remain in the PPOs. Further, for the new PPO contracts to perform optimally, a stable population is also needed making this the crucial time for the full transition. This will put us on a shorter path to bring future PPO premium increases back to the single digits.

[SLIDE CHANGE]

HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF JARZOMBEK: This slide shows the differences between the continued phase-in approach and making the full transition to a single risk pool in 2025. With a continued phase-in, the Basic PPO would see an approximate 15 percent premium increases, including A 3.7 percent downward premium adjustment for the second year of the three-year phase-in. With this increase, we project a membership loss of about 10 percent this 2025. With the full transition next year, the Basic PPO would see an approximate 10 percent premium increase, with 7.5 percent downward premium adjustment. We project a loss of five percent of its membership cutting it in half.

While the one risk pool transition is helping the PPOs tremendously, on the flip side, the upward impacts to the HMO plans are relatively modest. The Basic HMO would

see an average premium increase of 7.44 percent for the continued phase-in to one risk pool. This includes the 1.3 percent upward adjustment. The HMOs would have a 2.7 percent membership gain as a result. And for the full transition, the HMO premium increase is 8.72 percent due to the larger 2.6 percent upward adjustment. Under this scenario, we project a 1.5 percent membership gain for the HMOs

The bottom line here is the sooner we complete the transition to one risk pool, the quicker we can stabilize the Basic program by minimizing migration from the PPOs to the HMOs.

[SLIDE CHANGE]

HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF JARZOMBEK: Now, let's take a look at the proposed plan premiums for next year and how they are impacted under each scenario.

[SLIDE CHANGE]

HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF JARZOMBEK: Starting with the Basic HMO plans. And as a reminder, the numbers throughout this presentation are all the single party premiums. From left to right, we have the 2024 premiums and updated 2025 premiums with a continued phase-in to one risk pool. The weighted average again under the -- this scenario is 7.44 percent, which

does include the 1.3 percent associated with the one-third step to a single risk pool. The green session -- section, or the columns on the far right, show the HMO premiums under the recommended full transition to one risk pool in 2025. So it shows an additional 1.3 percent premium increase for an average of 8.72 percent.

These comparatively modest increases for the HMOs will help the PPOs tremendously as it reduces the PPO increase by five percent. Let's take a closer look.

[SLIDE CHANGE]

HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF JARZOMBEK: For the PPO plans and with the action you just took with the intent to award the third-party administrator and population health management contracts, we will focus on Option 1 with Blue Shield and Included Health starting in 2025.

With a continued three-year phase-in, the Basic PPOs would see an approximate 15 percent premium increase. With this increase, again, we project a membership loss of about 10 percent.

Moving to the green section, or the section on the far right, with the full transition, the PPOs would see an approximate 10 percent premium increase and only leave about -- lose about five percent of its membership, again cutting that outward migration in half.

Comparatively small increases to the HMOs will help the PPOs a great deal. So I'll pause here and ask if there are any questions before moving forward.

CHAIR RUBALCAVA: I have one question.

COMMITTEE MEMBER TAYLOR: Not right now.

CHAIR RUBALCAVA: Okay. No questions.

Please continue.

[SLIDE CHANGE]

HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF JARZOMBEK: Moving on to the Medicare plans. 2025 is going to be an extremely challenging year for Medicare premiums. This is the second year we're experiencing an overall premium increase for the MA plans after having three consecutive years of overall MA premium decreases. The average premium increase for Medicare Advantage plans is just under 14 percent.

[SLIDE CHANGE]

HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF JARZOMBEK: Next, here are the Medicare Supplemental plan premiums. The proposed 2025 premiums increase about 30 percent from 2024, mainly due to the Inflation Reduction Act impacts to the pharmacy rates. I'll explain what these changes are when we get to the Medicare section.

[SLIDE CHANGE]

HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF

JARZOMBEK: Now, I'll walk through each Basic HMO plan.

[SLIDE CHANGE]

HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF JARZOMBEK: First is Anthem Select. We have two tables on each slide. The top table in blue shows the risk adjustment impacts with the continued phase in to one risk pool. The bottom table in green shows the premium impact and risk -- premium and risk adjustment impacts with the recommended full transition to a single risk pool in 2025. I'll walk through the bottom green table. It shows the 2024 premium, 2025 -- the plan's 2025 premium before risk mitigation and the plan's risk score. Plans with a score greater than one, with one being the average, have sicker lives and their premium is lowered with the impact of risk adjustment. Plans with risk scores less than one have healthier lives and will see risk adjustment increase their premium.

Anthem Select has a risk score of less than one, meaning that the plan has healthier than average members in the Basic portfolio. Therefore, the 2025 premium is increased and that amount is shown in the fourth column, $79.69.

In the final two columns you will see the proposed 2025 premium and the percent increased from '24. For all plans, the cost drivers chart to the right

reflects the full transition to one risk pool in 2025 and breaks down the premium impacts by component. The first bar is medical cost and they contribute about three percent to the -- three percent increase to the premium. The next bar is pharmacy, which contributes about five percent impact to the premium. The third bar is program changes, which shows a very small premium increase associated with adding the travel and doula benefits next year. The fourth bar is labeled "other", and includes overall changes on administrative costs both CalPERS and the plans. It also includes changes in the family mix of plan's enrollment.

Anthem Select lost about 17 percent of its membership during open enrollment and that led to a one percent downward premium impact due to the change in the family mix. Risk mitigation is more than three percent of the total premium increase. This is the increase on the risk mitigation impacts from 2024 to 2025. Adding this all together, the green bar on the far right, the last bar on the far right shows an overall increase of 10.39 percent with the full transition to one risk pool. For simplicity, and as we go through the remainder of the plans, I'll just share the risk adjustment impacts from the bottom green table which is the tran -- full transition to a single risk pool.

[SLIDE CHANGE]

HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF JARZOMBEK: Moving to Anthem Traditional. This is a broad network plan offered in many high-cost, low-competition areas of the state. Anthem Traditional is a plan that we have concerns about it's longterm sustainability in our program. We will continue to closely monitor this plan to ensure it remains a viable product for CalPERS. Traditional's 2025 premium increase is nine and a quarter percent.

[SLIDE CHANGE]

HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF JARZOMBEK: Blue Shield Access+ is also a broad network HMO. In the last few years, Blue Shield has been helping us achieve our goal of having an HMO or EPO option available in all rural counties. In 2023, Access+ expanded into 11 rural counties through their EPO network. In 2024, the EPO exapands into Del Norte and San Benito counties. This plan has a 2025 premium increase of eight and a quarter percent.

[SLIDE CHANGE]

HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF JARZOMBEK: Blue Shield Trio is a narrow high performance network that started with CalPERS in 2020 in six counties. It has been expanding its footprint over the past few

years to bring a low cost alternative to more of our members. In 2024, it's available in 19 counties and is expanding into Contra Cost, Shasta -- and Shasta counties in 2025. The Shasta County expansion is pending DMHC approval. Blue Shield did not project a rate impact for these expansions. Trio's 2025 premium increased by 12.2 percent. And one of the main cost drivers is medical costs. Trio's membership increased by 34 percent during last year's open enrollment with the risk improving by about six percent. A significant portion of the membership gains came from Monterey County, where the membership tripled growing from about 2,100 members to 6,800 members, which was higher than Blue Shield's projections.

As we know, medical care in Monterey County is some of the most expensive this California. Overall, the projected medical cost contributed seven and a quarter percent to the 2025 premium increase. The improvement in Trio's risk score also contributes to this with about five and three-quarters percent. Trio has an overall 12.2 percent increase for next year.

[SLIDE CHANGE]

HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF JARZOMBEK: Health Net Salud y Más is a very narrow network that provides services in six Southern California

counties, as well as in Mexico. For next year, Salud y Más is expanding into Imperial County, and that is pending DMHC approval. Medical contribute to almost seven percent of the premium increase. Salud y Más has been the lowest premium plan in our basic program thanks to its low cost narrow network and Southern California service area. Their membership has been growing and members are starting to use more expensive providers. Similar to most plans, pharmacy contributed about three and a half percent to the increase. This was due to the increase in utilization of brand and specialty drugs.

The Imperial expansion adds about 1.2 percent to the increase and risk mitigation contributes about three percent to the increase. Overall, they are seeing a 14 and three-quarter percent increase for next year. However, they are still the lowest cost basic plan in our portfolio.

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HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF JARZOMBEK: Kaiser Permanente is the largest health plan in our basic portfolio making up about half of the total basic membership. For 2025, Kaiser is pursuing a partial county expansion into Monterey with no projected rate impact. This will be the third HMO that CalPERS has brought into Monterey after Anthem Select and Blue Shield

Trio. For this expansion, Kaiser is opening up a new Salinas medical office in the northern part of Monterey County, with outpatient care, including adult and pediatric primary care, OB/GYN, behavioral health, laboratory and pharmacy services. In-patient care will be provided at their affiliated hospital, Watsonville Community Hospital. The Monterey County expansion is pending DMHC approval. And Kaiser reports that they are very confident that this will be approved. Kaiser's 2025 premium increase is just over eight percent.

[SLIDE CHANGE]

HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF JARZOMBEK: Sharp is a narrow network plan available only in San Diego County. Looking at the cost drives for them, Medical inflation and -- medical inflation and pharmacy contribute to about five and a half percent of the premium increase. The premium increase is offset by risk mitigation changes of about 1.2 percent. Sharp had high medical costs in 2023, driven by the increased number of members with chronic conditions. The increase in medical costs resulted in a higher risk score, and therefore Sharp received a downward risk adjustment impact compared to 2024. Sharp's 2025 premium increase is four and a quarter percent.

[SLIDE CHANGE]

HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF JARZOMBEK: Turning to UHC Alliance, the premium increase is mainly due to medical costs contributing to over four percent and pharmacy about three percent. Risk mitigation increases the premium by about two percent. Overall, their preliminary -- their premium increase is 8.88 percent.

[SLIDE CHANGE]

HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF JARZOMBEK: UHC Harmony is a narrow network currently available in seven counties, five Southern California counties and two Northern California counties. Harmony is expanding into Napa, Contra Costa, and Solano counties in 2025. UHC is honoring their commitment from last year's HMO solicitation to expand harmony into areas of the state where lower cost plans aren't prevalent while continuing to provide competitive pricing. As you can see from the chart, about half of the premium increase is driven by medical and pharmacy costs and the other half is driven by the Northern California expansion. Risk mitigation increases Alliance's premium by about two percent. Harmony's premium increase is about seven and a half percent.

[SLIDE CHANGE]

HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF

JARZOMBEK: Rounding out the Basic HMO plans is Western Health Advantage. Western Health Advantage initially proposed to expand into Fresno, King, and Madera counties for 2025, and that expansion was approved by the Board last November. Unfortunately, Western Health Advantage has not yet been able to secure the necessary provider contracts for 2025, but continues to pursue them for '26.

Most of the premium increase for WHA came from the risk mitigation impact. Previously, Western Health Advantage had a sicker than average population, which meant they received a positive downward impact of risk adjustment to their premium. However, their membership increased by 28 percent during last year's open enrollment, with their new members being some of the healthiest in the Basic HMO program. Those new members had an average risk score of about 30 percent below the average HMO risk score, thus improving WHA's overall risk score by nine percent. This created a risk mitigation impact that contributed approximately 10 and a half percent to the total premium increase. Western Health's premium increase for 2025 is just over 13 percent.

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HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF JARZOMBEK: And now, I'll move on to the PPO plans.

[SLIDE CHANGE]

HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF JARZOMBEK: As we've talked about a number of times now, PERS Gold and PERS Platinum Basic premiums will have a 15 percent increase with the continued two-year phase-in to one risk pool. This -- our recommendation is on fully moving to one risk pool with a premium increase of about 10 percent. The main cost drivers here were the medical and pharmacy costs, raising the premium by over 15 and a half percent. Through this solicitation, we are investing in a population health management vendor. The new administrative services fees contribute about 1.7 percent to the premium increase. But this was done to improve quality and sustain costs.

These premiums continue to include the surcharge of four percent on Platinum and five percent on Gold to replenish the Health care reserve. The premium surcharge levels are the same as they were for '24.

[SLIDE CHANGE]

HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF JARZOMBEK: Here's a chart compiling all of the preliminary risk-adjusted premiums. Please note that the premium ranking is very similar to 2024 under the full implementation to one risk pool.

[SLIDE CHANGE]

HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF

JARZOMBEK: Let's thousand turn to the Medicare plans.

[SLIDE CHANGE]

HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF

JARZOMBEK: As I mentioned earlier, high Medicare rate increases are -- we are seeing in 2025 are mostly driven by significant changes being made by the federal government. Of those, the most notable are due to provisions of the Inflation Reduction Act. As background, the IRA was signed into law in 2022 and designed to provide financial relief for millions of people with Medicare by expanding benefits lowering out-of-pocket costs to consumers, and strengthening the Medicare program for the future. It's the most significant change to prescription drug financing since the creation of Medicare Part D in 2006. The changes have downstream impacts to all Part D sponsors and are not unique to CalPERS.

The first key change for 2025 is to the benefit design that CMS uses to calculate an individual's maximum out-of-pocket costs. This change is designed to lower out-of-pocket costs for consumers when getting prescriptions. Here's how it works. The IRA imposes a $2,000 maximum out-of-pocket cost for an individual each calendar year. New, in 2025 is that the IRA allows plan paid costs to count towards the member's $2,000 maximum, thus reducing costs for consumers, but significantly

increasing them for purchasers like CalPERS. The result is that some members will be considered to have hit the out-of-pocket maximum after paying considerably less than $2,000, resulting in the member paying less in 2025, even though CalPERS has not changed our benefit design.

Next, and more impactful to rates, is a change to the way CMS provides subsidies to health plans for pharmacy benefits. The subsidy changes impact CalPERS plans differently. And amongst our plans, we have both winners and losers. Here are the details.

Plans that have integrated systems or have fewer members on high-cost drugs will benefit from this change by receiving higher subsidy payments. This is intended to reward those plans that have more effective care management when it comes to providing pharmacy benefits. Kaiser and Sharp are examples of plans that have efficient care management of their members as well as fewer members on high-cost drugs, as they have a greater usage of generics over brand drugs. So we are seeing Kaiser and Sharp actually benefit from these changes.

Conversely, plans that are less efficient in their management of prescription drugs or have more members on high-cost drugs will receive lower subsidy payments going forward.

The last item to point out about the IRA is the

timing of when CMS will announce their reimbursement rate for 2025, which further complicates our rate-setting process. CMS will announce the change in subdisease in late July this year, which create a timing issue for the Medicare plans and Optum to project the 2025 costs, as we finalize our premiums mid-July.

Most of the plans included additional conservatism in pricing assumptions to account for the greater uncertainties in the subsidy projections, which contribute to a substantial premium increase for some plans.

Because of the changes CMS is implementing, we engage a third-party actuarial firm to further verify the pharmacy rating assumptions used by the health plans and Optum's to avoid unnecessary premium increases. Through our testing of these assumption, we have confirmed that all of these increases are reasonable. However, for the fully ensured plans that are not benefiting from CMS's changes, we are taking an additional step to further prevent unnecessary increases. We are doing this by establishing a premium stabilization fund for Blue Shield and UHC. This means that once the CMS subsidy amounts are announced after our premiums -- our rates are set, any additional increase that was added to the 2025 premiums will accrue in the premium stabilization fund. This fund

is designed to capture the difference between the announced drug subsidy minus the amount included in a plan's final 2025 premium.

Any accrued funds will then be returned to CalPERS. This is a big win for CalPERS, as it ensures that any potential unnecessary premium increases will come back to us and not simply be turned into profit for the health plans. We'd like to acknowledge the leadership at both UHC and Blue Shield for working together with us on this important safeguard for our members.

[SLIDE CHANGE]

HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF JARZOMBEK: Now, let's move on to the Medicare Advantage plans.

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HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF JARZOMBEK: Anthem's proposed initial premium is a 20 percent -- 21 percent increase. This increase is mainly driven by the pharmacy cost due to the IRA changes.

[SLIDE CHANGE]

HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF JARZOMBEK: Blue Shield's nationwide Medicare Advantage plan started with CalPERS in 2022 with just under 600 members. In just two years, it has grown to roughly 5,200 members. Shield is proposing a 14 percent rate increase

for next year. Their medical increased significantly due to cost volatility when the membership grew nearly tenfold in just two years. It's normal to see volatility on a new Medicare Advantage plan premiums for the first few years, as enrollment grow and there's a lack of experience to make accurate projections.

As you can see on the chart, they have a projected a significant drop in their pharmacy costs. This is mainly driven by the large increase on the pharmacy rebate assumptions, which are offset by the increases pharmacy trend and IRA impacts. And as I mentioned earlier, we are establishing the premium stabilization fund to capture the difference between the announce drug subsidy minus the amount that we assume in their final rate. This will prevent any unnecessary increases that may occur for 2025.

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HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF JARZOMBEK: Kaiser Senior Advantage is proposing a five and a half percent increase. Kaiser is showing a medical increase of almost 13 percent and a pharmacy decrease of almost eight percent, mainly due to the IRA changes. As I noted, Kaiser will benefit from the increase in federal subsidies.

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HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF JARZOMBEK: Kaiser Senior Advantage Summit was a new plan for CalPERS in '23 and available in California only. For 2024, Summit is available in the eight out-of-state regions matching where their Senior Advantage and their Basic plans are available. The 2025 proposed premium for Summit is also five and a half percent from 2024. The same increase applies to the out-of-state plan too.

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HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF JARZOMBEK: Sharp is proposing a 6.2 percent increase from last year. This product was due -- introduced in 2021 and only has about 450 lives in it. The main cost driver is pharmacy, which Sharp administers, at eight percent, and it was mostly offset by a decrease in their medical of almost three percent. Just like Blue Shield's Medicare Advantage plan, Sharp is also facing the same volatility challenges as they are a relative new and small plan.

[SLIDE CHANGE]

HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF JARZOMBEK: UHC's group Medicare Advantage plan is a nationwide plan. UHC is proposing a 30 percent increase for next year. About nine percent of the premium increase is contributed to medical and 19 percent is to pharmacy. UnitedHealthcare is our second largest Medicare Advantage

Plan and has a stable population. For this plan too, we are establishing the premium stabilization fund to capture the difference between the announced drug subsidy minus the amount we assume in their final rate submission.

[SLIDE CHANGE]

HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF JARZOMBEK: UHC's Edge plan has a proposed premium increase of 50 percent from last year. This plan started in 2022 with $0 copays for most services and now has over 5,000 members. With United's proposed rate increase, Edge will go from being the fifth lowest cost Medicare plan to the most expensive Medicare Advantage plan we offer. This high premium set s a dangerous precedent. With such an unsustainable rate increase, we don't see this plan adding value to our program. Therefore, we recommend removal of Edge from the CalPERS Health Benefit Program.

Current Edge members can continue with the same Medicare providers as they are seeing by switching to another Medicare plan. For members who don't make a plan change later this year during open enrollment, they'll be adminsitratively transferred to UHC's Group MA plan. Should the Board approve this recommendation, we will communicate this change to members through our open enrollment communications.

[SLIDE CHANGE]

HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF JARZOMBEK: Western Health Advantage is no longer offering their MyCare Select Medicare Advantage plan in 2025. The decision applied to their Medicare book of business and not just to CalPERS. While this is disappointing, it is not surprising, as the landscape for MA plans has changed drastically since they'd introduced their plan just a few years ago. Western Health Advantage has sent letters to members about this last week and CalPERS will also communicate this to members, along with their options, through our standard open enrollment communications.

Blue Shield's MA plan will be the default for members who do not enroll in a new Medicare plan during open enrollment. UHC's Group MA plan will be the default plan for members in that Napa County.

[SLIDE CHANGE]

HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF JARZOMBEK: Moving on to our Medicare supplemental plans.

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HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF JARZOMBEK: The average here is a 30 percent increase from last year. Again, the primary driver for this premium increase was pharmacy cost, due to the Inflation Reduction Act impacts.

[SLIDE CHANGE]

HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF JARZOMBEK: On this slide, we have the compilation chart of the proposed Medicare premiums for 2025. I'll note that if Edge were to remain in the portfolio, it would become most expensive Medicare Advantage plan we offer. It's shown here on the second bar from the left.

[SLIDE CHANGE]

HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF JARZOMBEK: For next steps, the CalPERS team will finalize the premiums and then present them at the Board off-site for your approval. Then we will communicate the final premiums in advance of open enrollment. This concludes my portion of the presentation and we're happy to take any questions

CHAIR RUBALCAVA: Thank you, Rob. We do have questions from the trustees. We'll start with President Taylor.

COMMITTEE MEMBER TAYLOR: Thank you. So I had -- I guess my question right -- the first question is we're going to finalize premiums. Do you foresee anything coming down in between now and then?

HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF JARZOMBEK: There may be some slight changes to the pharmacy portion, just as we work through some of the assumptions more. But again, it will not be substantial,

so they should -- I anticipate them being largely similar --

COMMITTEE MEMBER TAYLOR: The same.

HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF JARZOMBEK: -- to what we have today, yes.

COMMITTEE MEMBER TAYLOR: Okay. So -- and then -- so the risk mitigation, if we move, rather than doing it two years, we're moving it into one year, that's the recommendation, correct? Because otherwise we won't have the funds. So okay. Not favorite thing to do.

CHIEF HEALTH DIRECTOR MOULDS: I should just -- I -- our risk of not having funds goes up. And so we are not projecting to not have the funds under either scenario, but there is a risk, and it is significantly higher with the two-year transition versus the one-year transition.

COMMITTEE MEMBER TAYLOR: In case prices are higher. Okay.

Okay. And then I thought I'd mentioned, when I mentioned in closed session, the CMS benefit pharmacy change I think is confusing enough for everyone, not just the Board members, that we may want to cover that and how that has impacted pricing for us, which, you know, you get this good news on the news that our prices are going down for Medicare patients, et cetera, but then it impacts

health care rates overall. So if I had mentioned, and I think we did it as Board direction, that it would be a good idea to have some -- an educational session on this, so I just wanted to mention that.

CHIEF HEALTH DIRECTOR MOULDS: Yeah. And thanks, we'll take that as direction from the Board. I'll mention again that we are going out to bid on our pharmaceutical benefit manager in -- over the summer. We have been struggling with this question, not just because the changes at CMS are, I think the generous term is somewhat fluid, but also understanding better how we might adapt our own benefit to better take advantage of some of those changes. So it would be enormously helpful for us to bring experts in to go in depth about this, but also in our thinking about where we want to take our drug purchasing in this new solicitation.

COMMITTEE MEMBER TAYLOR: Yes. I think we -- it might give us some opportunities maybe.

CHIEF HEALTH DIRECTOR MOULDS: Agreed.

COMMITTEE MEMBER TAYLOR: I mean, I know there's concern over the pricing, so let's figure out what we can do to mitigate some of the concern.

And also, I just want to -- I'll state that while I understand these prices are high and I -- and they're not insignificant. So let's -- when I look at HMO prices,

which is most of my members, except for my out-of-state members -- David, sorry -- that 10 percent is 10 percent. You know, we don't have a 10 percent raise coming. We get a three percent raise. So this is -- I want to make sure that whatever we're doing hopefully mitigates future continuous increases. I mean, I know we're going to have increase, but I mean 10 percent is kind of high.

CHIEF HEALTH DIRECTOR MOULDS: Agreed. We're disappointed in them. We're -- the recommendations that we're making are to get to stability on the PPO side as a quickly as possible. That, on the basic side, is what is drying our costs this year. The base right on the HMO before the transitions is closer to six percent --

COMMITTEE MEMBER TAYLOR: Correct, yeah.

CHIEF HEALTH DIRECTOR MOULDS: -- which is below medical trend anationall. That's important. And tha's where we always want to be. So, yes, they're too high. This is the path that we believe will get us most quickly to single digits across the Board.

COMMITTEE MEMBER TAYLOR: Single digits for not just the HMO Basic, but the whole --

CHIEF HEALTH DIRECTOR MOULDS: For the PPO as well. That's -- that obviously is the goal. I mean, low single digits is -- low single digits is the goal, but certainly, you know, the short-term goal is to bring the

PPO down. The PPO will continue to see elevated costs, as long as that surcharge is in place. This also shortens the surcharge period from the five to six years to the probably about four-year period. We could see a little bit of relief in the fourth year.

COMMITTEE MEMBER TAYLOR: So that will be good. And then finally, I just want to reiterate, so that everybody heard, it was the UnitedHealthcare -- what's the name of that one?

CHAIR RUBALCAVA: Edge.

CHIEF HEALTH DIRECTOR MOULDS: Edge.

COMMITTEE MEMBER TAYLOR: Edge that we're getting -- we're not going to continue with or we're looking at not continuing.

CHIEF HEALTH DIRECTOR MOULDS: Well, we -- we're recommending that you would be taking action on that in July.

COMMITTEE MEMBER TAYLOR: Okay.

CHIEF HEALTH DIRECTOR MOULDS: Yeah.

COMMITTEE MEMBER TAYLOR: Okay. I just wanted to clarify.

CHIEF HEALTH DIRECTOR MOULDS: If you're so inclined.

COMMITTEE MEMBER TAYLOR: All right. Thank you very much.

CHAIR RUBALCAVA: Thank you, President Taylor.

We'll continue with Trustee Pacheco.

COMMITTEE MEMBER PACHECO: Thank you, Chairman Rubalcava, and again, thank you, Rob, for your presentation. It was very, very thorough and I really appreciated that. And again, I want to thank your team as well.

My first question is actually more a broader question, in terms of the cost influencers and major trends. You mentioned that the medical inflation has increased the unit price as well as the continuing high pharmacy costs. And can you elaborate a little bit more on the increased unit price and where that's -- what's the driver behind that.

HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF JARZOMBEK: So, yeah, I'll have Dr. Albers come up and help out with the question. So we're seeing increased usage in high-cost specialty drugs and also brand name drugs. And so one thing that has happened over the past 18 months or so is that some have -- there have been approved -- new indications have been approved for some of these high cost brand name and specialty drugs. And so there's -- and that means there's more utilization of those drugs, because they're being used for new things. And so this is where that we're seeing it happen and we're

seeing it happen on a regular basis. And there's more in the pipeline that's going to come down where we're having high cost drugs being used for new things.

So, Dr. Albers.

COMMITTEE MEMBER PACHECO: Thank you.

MEDICAL CONSULTANT II ALBERS: Sure. Mostly we're talking here about the pharmacy costs and not so much the medical costs. On the pharmacy side, as I think you're all aware, because it's always in the news, there have been a number of brand name drugs that have come out recently, particularly I know you've heard about the GLP-1s.

COMMITTEE MEMBER PACHECO: Um-hmm.

MEDICAL CONSULTANT II ALBERS: They are all over the news as treatments for weight loss, but actually they were originally developed for the treatment of diabetes, as I know you're aware, and they're very effective in the treatment of diabetes. So, the utilization of those drugs has increased quite dramatically in the past couple of years. And as Rob mentioned earlier, there have been changes in the guidelines that really make them first-line therapies for many patients who do have diabetes.

So that has contributed quite a bit to the increase in our pharmacy costs and that's happening across the nation. That's not unique to CalPERS in anyway.

Additionally, those drugs, while approved for weight loss by the FDA and for diabetes, they're getting new indications as well. So you may well have heard that recently Wegovy, which is one of the GLP-1s was approved not just for the treatment of diabetes or weight loss, but for a specific population of people who are at high risk of an adverse cardiovascular event like a stroke or a heart attack. If those individuals happen to have obesity or be overweight, then the FDA has approved the use of Wegovy to treat them.

So CalPERS is covering for that indication now, because it's not primarily for weight loss. It's for the prevention of an adverse cardiovascular event. And we anticipate that there will be other FDA indications coming down the road as well. So we'll evaluate each of those as they happen, but it's sort of a tsunami of new drugs and new indications that's been happening.

COMMITTEE MEMBER PACHECO: And that's what's driving the cost then, basically in that -- in that orbit, in that universe?

MEDICAL CONSULTANT II ALBERS: For pharmacy, yes, not just the GLP-1s but that's certainly a large part of it, but just again this wave of new medications that is coming.

COMMITTEE MEMBER PACHECO: Okay.

CHIEF HEALTH DIRECTOR MOULDS: Yeah. I'll add that, you know, the other -- the other piece of this is that we've -- you know, there are a number of drugs that -- and this is a -- this is a pharma technique, but evergreening their patents. And then when they get through the patents doing other things that I won't go into now, but happy to, at some point in the future --

COMMITTEE MEMBER PACHECO: Sure.

CHIEF HEALTH DIRECTOR MOULDS: -- maybe when we talk about drugs over the coming year, but make it less common or even less cost beneficial to transition to the generic substitute. So for some of the rheumatoid arthritis drugs and the bowel disease drugs, which are very expensive biologic interventions, we had anticipated seeing price relief when we had generics come online. And that has been much slower than we had hoped.

So there are a number of things that are happening, but at a very high level, you know, it is great that we come up with new pharmaceutical interventions. They are ridiculously priced and causing us grief and causing our members grief, the pricing that comes along with them.

COMMITTEE MEMBER PACHECO: Yeah, that's very interesting. Thank you for that question. My next question is on the HCF investments that are now fully

liquid due to the immediate cash needs. If you can elaborate, you mentioned that this is unique, a little bit more. And since we did something -- we did -- we changed the allocation of that yesterday, can you elaborate more no that?

HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF JARZOMBEK: Sure, so the -- it's unique in the sense that a fund of this -- a fund -- it's severely underfunded right now. And it's supposed to have more around the ballpark of four hundred to five hundred million dollars in it. And so when you have that much -- you have that much -- that large of a sum or that many -- that amount of money, then it's typically invested in other things other than liquid assets. And so because we're at -- we're in a position where we can't lose any more principal and don't want -- we just can't afford to lose any more principal, it needs to be in a much safeer option. And so that's why we took -- the Investment team made the recommendation to officially move it into like a hundred -- a hundred percent liquidity.

COMMITTEE MEMBER PACHECO: Um-hmm.

HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF JARZOMBEK: And so again, once it will come back up, which we hope it will come over the coming years, then we will look at what are the appropriate investment classes for it

to be invested in, so it's not just sitting there in cash, because we shouldn't need it in a cash -- in as much cash as we need it today. And so that will be evaluated once it is in a better position, a funded status position.

COMMITTEE MEMBER PACHECO: So it's going to be the cash equivalents, right?

HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF JARZOMBEK: It needs to be cash equivalents, in case we do happen to get higher claims coming through that we need to be able to pay. So we don't want it to be tied up in investments where we can't really get it out and have the potential to lose more of the principal.

COMMITTEE MEMBER PACHECO: Oh, I see then. Now, I understand the rationale why we want to go into the -- into the single risk pool sooner than later in terms of trying to bring that back down to the single digit PPO increases moving forward.

The other question I have is -- just a comment actually on the Kaiser Permanente. You had mentioned Watsonville Community Hospital. And they -- and the Monterey Bay area. And can you just elaborate more on that outreach in your presentation?

HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF JARZOMBEK: So I know that everything is on track with them for -- to get the DMHC approval. They're still

working through all those things. The hospital they've -- or they're contracting with is the Watsonville Community Hospital. I don't really have any more details than this at the moment, but we certainly pass those along once everything is hopefully approved. Again, Kaiser said they are very confident --

COMMITTEE MEMBER PACHECO: Yeah.

HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF JARZOMBEK: -- that DMHC will approve this. So we expect that to be -- that happening for our members.

COMMITTEE MEMBER PACHECO: Well, as a point of privilege, I from Watsonville, born and raised and from there. And I -- and I -- and I actually was born in Watsonville Hospital, so I find it very interesting. And I also think it is a community that is very underserved. It's an agricultural community. The -- and very prominently Latino in -- and so it is -- it is -- it is really great that we are making that outreach in that that community, especially in that particular part of the Monterey Bay, Santa Cruz County area. So thank you for that comment.

HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF JARZOMBEK: Thank you.

COMMITTEE MEMBER PACHECO: Those are my questions, sir. Thank you.

CHAIR RUBALCAVA: Thank you, Trustee Pacheco.

Now, we'll go to Vice Chair Palkki.

VICE CHAIR PALKKI: Thank you. Not so much a question, but really more of a comment. Watching these sort of percentages on the pharmacy side, where they -- some are in the negative, some are in the -- in their extremes. And so it's frustrating to see those extremes and not quite understand what is happening to cause those extremes, but I am excited to hear that we are involved with these national councils, and hopefully we can use our voice to bring some awareness to some of those issues, so that we're really competitive when it comes to pharmaceuticals on a more global level. So thank you.

CHIEF HEALTH DIRECTOR MOULDS: No, thank you for that. And I'm -- you know, I'm really excited to -- in the same way I was excited about the PPO solicitation, I'm really excited about the PBM solicitation, because I think the options that exist in the world are more than they were the last time we took this up. And I want to bring the same spirit of innovation that went into the PPO work to the PBM work, because we need to be doing much better on pharmacy costs. It's -- they're driving increasingly higher percentage of our overall costs and I think we can be doing better for our members.

VICE CHAIR PALKKI: Thank you.

CHAIR RUBALCAVA: Thank you.

And I have Mr. -- Delegate Frank Ruffino for Treasurer Ma.

ACTING BOARD MEMBER RUFFINO: Thank you, Mr. Chair. I just have a quick question again about the proposed rate increases, right? And I want to premise the question too, that we'd recognize this is nothing unique to CalPERS. So even California, you know, the national this -- this is a national issue and we all struggle on what we need to do and what we're doing with health care rate.

But with the proposed rate increases for the Basic PPO and Medicare plans, can you maybe elaborate just a bit more on the strategies that are in place to mitigate the financial impact on our members, especially, you know, considering the high medical and pharmacy trends, and the significant premium increases projected for 2025?

CHIEF HEALTH DIRECTOR MOULDS: I can start. The -- you know, the big one is trying to stabilize the PPO as quickly as possible, which we've talked about and the redesign of the PPO that we brought earlier to -- you know, again, we're -- we have guaran -- total cost of care guarantees, quality guarantees built into that product that didn't exist prior. We are really optimistic about the ability of the new PPO to perform on the cost front,

because their fees are tied to their ability to hit really, frankly, aggressive have spending growth targets. So we are the first entity that I am aware of that has tied its -- any product to the Office of Health Care Affordability spending growth targets of three percent. That's much lower.

I mean, we're starting lower than where we have been historically, but we're ending much lower. And these are out there. And credit to Blue Shield for being willing to commit to that journey with us, but -- so, you know, this year, I don't have a great answer for you. We're trying to get these down as quickly as possible and a number of the recommendations, including the recommendation to transition to a single risk pool in one year versus two is to get this -- that product back into the normal range as quickly as possible.

ACTING BOARD MEMBER RUFFINO: Thank you. And I really appreciate that. And some of the things you just mentioned, you know, stabilize the PPO, the single risk pool and so on and forth. Great, I mean, it's -- how do we communicate? How do we make a better -- and this is not meant to criticize the process, but it's just -- the reality is that our average member out there, and I'm -- and I'm not sure what kind of feedback you're getting from the stakeholders, but the reality is that it's hard to

understand, hard to comprehend about these specific. And I think the more we do to explain to our members and our stakeholders that we're not sleeping at the wheel so to speak. You know, we are really engaged and we're doing things that we are the first, as you just mentioned. I think the more we -- we perhaps should consider doing a lot more of that to -- I mean, in that communication space to explain.

CHIEF HEALTH DIRECTOR MOULDS: Yeah. No, I really appreciate the comment. We are and have heard similar comments. We're -- you know, Rob has talked through a lot of the communications strategy. We are open to other suggestions. When we were talking to the stakeholders about this, one of the things that I said is, look, you know, one of the stakeholders asked about the possibility of having CalPERS members do, you know, either virtual or in-person meetings with some of their members to help explain some of these changes, and what's behind them, and some of their -- some of the things that we're doing to mitigate the disruption, but also the general philosophy behind the product and what we're expecting to see in terms of quality improvement and reduction in overall costs. We are open to all of that.

We want to Make sure that we get the message out. We also want to hear back from our members. It's really

important, if this is not working for them, that we hear that. You know, when you do something big like this, there are always micro level -- hopefully micro level -- micro level adjustments that you need to make on an ongoing basis to make sure this works. And the only way often we get those is either through our grievance procedure, which is certainly not how we want to get them or through communications with stakeholders and through stakeholder groups. So thank you for that.

ACTING BOARD MEMBER RUFFINO: Yeah, excellent. Thank you. Thank you for, you know -- you know, for your answer. I would really -- we'd really appreciate it.

Thank you, Mr. Chair.

CHAIR RUBALCAVA: Thank you, Mr. Ruffino. Now, let us hear from the stakeholders. So our next -- next we'll have public comment on this item and we'll start with Mr. Larry Woodson and followed by J.J. Jelincic.

LARRY WOODSON: The mic on?

CHAIR RUBALCAVA: Yes.

LARRY WOODSON: Good. Good afternoon. Larry Woodson CalPERS, retiree. Thank you for the opportunity to comment. I also thank the staff for the special stakeholders briefing where we were able to get a look at these outrageous preliminary rates, sharp and cancer -- Kaiser excepted.

The Fortune 500 list was just released, and as I've done in past years, I want to point out to the Board your contracted health plans did quite well during the last year. Uniteedhealth Group once again was number five on the list with revenues of $371 billion, over a 14 percent increase over last year, and their profits increased to 22.3 billion. And again, they want large premium increases, 29 percent from Medicare Advantage. Anthem is now listed as Elevance on the list and they did quite well. They're 22nd. They did well in profits and in revenues and profits. Kaiser, though much smaller, did well as a non-profit, and they had profits of 4.1 billion.

These high premium increases against the backdrop of huge profits is just unacceptable. Please direct staff to go back and get them lower, especially the large increases.

I want to focus for a minute on Medicare Advantage in general as a huge driver of exorbitant costs. A new academic study in JAMA Internal Medicine details the enormous sums MA plans have cost taxpayers and the Medicare Trust Fund, and have called -- they've called for the Abolition of the program. They cite the non-partisan MedPAC study, which shows that MA plans have overcharged $612 billion more since 2007 than traditional Medicare would have charged for the same service, and 82 billion

more just in the last year alone, much of that has to do with the capitation payment model. Only legislation can serve this problem, but CalPERS can say no to unreasonable premium increases.

Lastly, another major increase -- contributor to rising costs is the increasing acquisition of health care by private equity. It's -- this results in less competition, high cost, staffing reductions, poor quality care, little transparency. Yesterday, I sent to all of you a email requesting you to endorse AB 3121 -- 29, which would give some accountability and transparency, and allow Attorney General review. I hope you are able to read the email and consider endorsing this bill during Danny Brown's legislative update in your Board meeting tomorrow.

Thank you.

CHAIR RUBALCAVA: Thank you.

J.J. JELINCIC: J.J. Jelincic, beneficiary.

You are trustees of a Health Benefit Trust. You have a fiduciary obligation to the beneficiaries to limit medical costs and defend affordable benefits. You are elected public officials in California. You have an obligation to fight escalating costs and medical inflation. You are not fiduciaries to the State and public agencies, although you sometimes talk like you are. I also know that the desire of the State and public

agencies play a role in your decisions. They also want you to limit health care costs.

Given these obligations and employer concerns, it is unclear to me how you can defend your policy of rewarding beneficiaries who pick high-cost, inefficient, high premium plans, while punishing beneficiaries who pick efficient, low-cost, low-premium plans. And also, your policy of saying, well, if you're willing to accept the limitations of an HMO, we're going to raise your premiums to subsidize those who will not accept those risks or those limits.

It could be that these contradictions explain why you've entered into a contract with the trust fund to waive liability claims. It's not clear to me how those contracts do not violate Government Code section 1090, but the people responsible for enforcing the law, the Attorney General and the public -- and the district attorneys, have not asserted a violation, at least not yet.

Looking at the numbers, it's clear that the insurance companies have gotten the message, do not hold down costs or we will punish you. Unlike your regulations, risk should be -- risk adjustments should be made based on the health of the insured not on the risk of bad vendor negotiations.

I urge you to relook at your policy on how you do

risk adjustment. Thank you.

CHAIR RUBALCAVA: Thank you.

We also have two people on the phone for to speak. Three.

STAFF SERVICES MANAGER I FORRER: Yes, Mr. Chair. We have Karen Speckling. Go ahead, Karen.

KAREN SPECKLING: Hi. My name is Karen Speckling and I am a CalPERS member. I live in San Luis Obispo on the the central coast and work for the State.

And (clears throat) -- excuse me. I -- this comment may be tangential to this item, but it felt like the best fit for me. I had a few questions. I actually went to the benefits fair that you had in San Luis Obispo this weekend, and was actually recommended to come and just make my comments, and my questions, and concerns before you guys.

My main concern is that we have a lot of State and public workers in my area, at colleges, universities, State prisons, and hospitals, Caltrans, and where I work at the Water Board. We are really struggling with being able to maintain and retain quality physicians in our area due to expensive operating costs. As far as I've been able to ascertain by speaking to my providers why they're leaving the area or going private and not accepting any insurance is because their reimbursement rates are so low

that it is not economical for them to be able to operate in the area based on, as I understand, a rural status rate.

As many of you know, it's very expensive real estate here in San Luis Obispo and in our county. And I just didn't know if your Committee or anyone on staff has heard of this concern and this issue. It's really hard to fine someone that's accepting new patients. I'm specifically on the PERS Gold PPO plan. And the wait time for most of the new -- the physicians that are accepting new patients for primary care, for example, is about a year and a half. And it's becoming quite burdensome for me, as someone who really needs the PPO, because of my medical history. I have a lot of specialists I see. And so, yeah, that's my concern, my comment.

Just a request that you guys consider maybe is there a way to adjust the reimbursement rates that the physicians get in our area through the existing contracts that you have or is there another provider -- I mean, another insurance option that we could have in our area that would maybe better serve us and or physicians and that's it. Thank you.

CHAIR RUBALCAVA: Thank you.

STAFF SERVICES MANAGER I FORRER: Next, we have John Willis to speak to Item 6a.

CHAIR RUBALCAVA: Please continue.

STAFF SERVICES MANAGER I FORRER: Go ahead, John.

JOHN WILLIS: Hi there. Yes. Good afternoon, everybody. John Willis, (inaudible). I was just trying to call in for the 2026 health plan. And it looks like that the 2025 is already -- almost (inaudible).

But I would appreciate for the 2026 health plan if we could look into the -- expanding the fertility services for members. You know, me and my wife are going through that and nothing is covered. I was just -- you know, it's a very challenging and stressful process to go through, obviously, very emotional as you could imagine.

But as, you know, a public sector employee, you can't afford the cost. And, you know, and I'm noticing the health plan we have, you know, there is some cost sharing with even doing the basic diagnostics, you know, the blood work, the exams, forget about doing the IVF or IU. That's my question. That's not covered.

So my recommendation is, if it's possible, for the health plans for 2026, if they are able to cover the diagnostics, right, and also maybe one session of the fertility services. I think that would be really, really appreciated. And it will help offset some costs, because it's really expensive. You know, here we are we're trying to, you know, be an advocate for reproductive rights. And

then on this side folks who are struggling to have a child cannot afford it.

And I'm realizing a lot of the, you know, large companies they actually offer fertile services as part of their benefits. And hopefully, you know, CalPERS has a huge pool of employees, maybe the health plans will be able to be a little bit more flexible in 2026 and expand their services or help reduce the cost for some of us, you know. And we're not that old. We're in our mid-thirties. So I would really, really appreciate that, because I'm looking into actually going into the private sector and leaving the public sector, because of this.

And I've noticed, there are some companies who are willing to do a hundred percent coverage for two sessions, which is really, really enticing. And I hope that, you know -- and it's very stressful to the employees, right, to go through this emotional process and then come to work. You know, there's now way you can turn that off as a human being. And top of that bills, the financial stress of all of that.

So it would be really, really helpful to do that. I did reach out to the Senate Public Employment Retirement Committee, also the Assembly committee and see if they could also look into this. But I would really, really appreciate if the staff could do some costing and bring

back -- bring that back to the Committee and see what those adjustments will look like, maybe, you know, health plans. But I would really really, implore you to -- if you guys could look into that. So thank you for your time.

CHAIR RUBALCAVA: Thank you for your comment.

Next speaker, please. Next public comment.

STAFF SERVICES MANAGER I FORRER: Yes, Mr. Chair. We have David Aguinaldo for 6a. Go ahead, David.

DAVID AGUINALDO: Hello, everyon. Again, my name is David Aguinaldo of Chicago. Thank you for hearing my comments.

So for Agenda Item 6a, definitely see that the rates are increasing across the Board. And I wanted to speak on behalf of myself and out-of-state workers and those who, you know, need to be on the PPO, not because we're choosing the PPO, but because we must. I would highly support the proposal to full integrate the risk pool beginning in year 2025. I know last year when the decision was between two years and three years, I had advocated for the two years at that point. That was not heeded and we're in the exact situation that I assumed we would be in, where we're continuing to lose numbers. So we need to make sure that (inaudible). So I firmly want to say I'm in favor of it.

A second point I want to make is the continued struggle with affordability. Even with the movement to the single risk pool, the plans -- the PPO plans, again all of the numbers that are used in these presentations are the full cost. The full cost is very helpful on the CalPERS end, but on the employee side, what we care about is what's coming out of our paycheck every month. And so just to give you an example. With a one-year phase-in, so everything going in in 2025, our lowest paid office worker, who gets paid $5,000 a month, will be paying $834 a month for her premiums alone before any care is received. So before any care is received, that's 17 percent of her paycheck out the window.

So if that tells you, you know, just how -- just how important this continues to be, I really hope that, number one, you move to that one-year risk pool. And what we really need is we need some very creative thinking, because I feel a lot of the ideas that are coming forward are tried and true methods. But these tried and true methods aren't getting us anywhere. We need to start thinking a lot more radically about what changes can be made. A lot of talk has been made about the increased cost of prescription medications this year due to GLP-1 antagonist, the semaglutides, all of that stuff.

CalPERS represents so many people. What doesn't

make sense to me and many others is why CalPERS is not flexing the power that we have. When I talk about, you know, just off the -- like what else can we do? See what we can do to try to do things differently. What if CalPERS set up their own manufacturing facility for prescription drugs? I know that sounds silly, but CalPERS has got a lot of money, and we need a lot of prescription drugs. And if they're not making it, I know that the Governor put out, you know, manufacturing insulin in the state of California. Why don't we do things like that? We have the resources.

So I just want to say like let's start flexing the power that exists within CalPERS, within the State of California employees, and with (inaudible). We need to get these health care costs (inaudible). And I stand with, you know, some of the former comments that were made that these health care companies are making insane profits, while at the same time having these massive (inaudible) that are causing our providers to not get paid for months and months and yet we're still in --

CHAIR RUBALCAVA: David, can you please start --

David, you've got to start ending your statement, please.

DAVID AGUINALDO: Okay. So all of that, my number one thing is one-year phase-in. Thank you,

everybody, for listening.

CHAIR RUBALCAVA: Thank you.

I want to thank all the public commentators -- public comments. We don't -- it's not our practice to always respond, but please understand that we do listen and staff -- we are working on some of those issues actually. So thank you very much. I think we should take a 10 -- a break for the reporter now, a 15-minute break, please.

Thank you.

(Off record: 3:01 p.m.)

(Thereupon a recess was taken.)

(On record: 3:16 p.m.)

CHAIR RUBALCAVA: Good afternoon, we're reconvening the Pension and and Health Benefits Committee. And we're going to proceed with Item 6b, informational agenda item, the prospective Long Term-Care Program rates, Don Moulds and Jared --

CHIEF HEALTH DIRECTOR MOULDS: Just -- yep. Thanks, Mr. Chair. The purpose of this agenda item is to share our intent to bring to the Board in September a proposal to raise rates for the Long-Term Care Program starting in January of next year. Based on the valuation report you heard in April, we believe that two rate increases will be necessary, a 10 percent rate increase

starting in 2025, and a second 10 percent increase in 2026. Combined, the two rate increases are projected to retore the Long-Term Care Fund to fully funded status.

I want to assure the Board and those listening that we do not take these rate increases lightly. While they are significantly lower than the last two series of rate increases we've needed to do, we recognize that they will create hardship for our Long-Term Care Policy and program enrollees.

Nonetheless, CalPERS has an obligation to ensure that the health of the Long-Term Care Fund is sufficient to meet the needs of its program participants into the future. Since the last rate increase, there are two considerations that are contributing to the need to raise rates. The first is a material change to our projections of our enrollees' future long-term care needs. Following industry standards, CalPERS annually reviews and makes improvements to the actuarial assumptions that are used to calculate the projections about future obligations. They apply these new assumptions to what we know about our current program enrollees.

In April, our Actuarial Office presented their latest reports using data as of June 30th, 2023, the last valuation cycle. The report stated that both claim incidents, how many people will go into claim and claim

termination, how long claims will last, required upward adjustments. These updates were used as a base -- as baseline assumptions and then adjusted to reflect the program's experience. Both are putting upward pressure on our rates.

The other factor that is contributing to the need to raise rates is worse than expected investment returns. Followed -- following a period of historic increases in interest rates, return on our investments of the Long-Term Care Fund, which are heavily exposed to the U.S. bond market, have significantly underperformed. For the 2021-2022 year, investments in the Long-Term Care Fund realized nearly a 10 percent loss, and for 22-23, they realized a loss of sixth-tenths of one percent.

As a reminder, the assumed rate of return on the portfolio is 4.75 percent. And while returns are projected to be positive for the year ending in a few weeks, and the prognosis for coming years is optimistic, poor performance during the two-year period necessitates an adjustment.

It's important to note that the entire long-term care industry has been facing the same challenges that our program is currently facing. In many cases, it has seen premium increases that are significantly higher than the ones we will be proposing in September. We recognize that

CalPERS policyholders have experienced prior rate increases. To bring the program back to being fully funded, the 10 percent increase would be phased in over two years beginning, as I said, in 2025.

We believe that it is imperative that we make these adjustments now. With the average age of a program participant currently about 77 years old, over the next few years, we're going to see high number of enrollees transition from being premium payers to being claimants. Recall, if you will, that enrollees stop paying premiums once they go into claim. What that means is that the burden of any potential future rate increases will be assumed by a smaller group of program participants. So failing to raise rates when necessary now will result in higher needed rate increases in the future.

We will becoming back to the Board in September with a detailed plan for these -- for the rate increases, including timing, the exact amount of the premium increases, and our plans for communications to policyholders and other key stakeholders.

Again, my purpose today is to inform you of where the program stands and of what our recommendations will be going forward. Fritzie Archuleta from the Office of the Actuary and Christine Reese from the Investment Office are here with me. Any of us Are happy to answer any questions

you might have.

CHAIR RUBALCAVA: We do have questions.

Trustee Pacheco.

COMMITTEE MEMBER PACHECO: Yes. Thank you. Thank you, Rob, for your questions. And I'd like to ask a few questions, more -- I have actually more of a basic question understanding. From the five-year history of the funded status and margin, as of June 30th, 2023, the funded status is 90 percent. And about two years ago at June 30th, 2021, it was 108 percent. I just want to understand, for my understanding, because at that time in 2021, the margins were 10.51 percent, but currently now it's at negative 19.01 percent. To clarify the -- this issue that's going on -- because from a lays perspective, the funded status is at such a rate that I don't understand the rationale of the increase. So can you please elaborate that with respect to the investment side?

INVESTMENT DIRECTOR REESE: Yes. From the investment side, what you're seeing when the funded status was over a hundred -- I believe it was 108 percent --

COMMITTEE MEMBER PACHECO: Um-hmm.

INVESTMENT DIRECTOR REESE: -- we had just come off -- we had just off of three positive investment years. We had earned seven percent, four and a half, and then almost 13 percent over the three-year prior period. The

following year, we -- it was a negative 10 percent investment earning. And then the year after that ending in 2023 was pretty much flat at about negative 0.6 percent. So those two years are what's contributing to the funded rate going down below 100 percent. And I'll let Fritzie add some actuarial information.

COMMITTEE MEMBER PACHECO: Okay.

DEPUTY CHIEF ACTUARY ARCHULETA: Hi. Fritzie Archuleta, Actuarial team. So to add to Christine's comments on the actuarial side, every time we do a valuation for the Long-Term Care Program, we have to make assumptions about the future, as far as the demographics go. And the projections, the demographic projections going forward have actually gotten worse. You heard Don said that, you know, the claims are expected to last longer and maybe be more expensive. And so on that front, that's why the costs have gone up on that side. So I would say that if you are looking at, you know, the total loss altogether, two-thirds of that is probably the investment side and the rest of it is the experience, the demographic experience.

COMMITTEE MEMBER PACHECO: And with respect to that, I mean, in the report, it also stated that the rising interest rates environment that we're in has contributed to the market value -- the decline in the

market value of the -- of the fixed assets. Now, if situations change or the economy changes and those interest rates begin to fall again, then it's -- I would imagine it's presumably the -- there would be the inverse of the value -- that valuations would go up, but if you guys could elaborate on that.

INVESTMENT DIRECTOR REESE: Yes, that's correct. So if interest rates go down, we would expect the value of the investments to go up. So as you say, it would be the inverse situation that we've experienced. I do want to also say that so for fiscal year ending in 2022, it wasn't just the fixed income assets that were negative. It was on the equity side as well. And so it was just a particularly bad year for the entire market, both on the equity side and fixed income.

COMMITTEE MEMBER PACHECO: Okay. And then yesterday, I think I asked the question regarding the -- you know, considering with respect to the affiliated funds, which is --

INVESTMENT DIRECTOR REESE: Um-hmm.

COMMITTEE MEMBER PACHECO: -- this is included as part of the affiliated funds, to -- perhaps if there's something on the roadmap in place to consider additional asset classes for the entire affiliation -- affiliated funds, I mean, perhaps this may be an area of exploration

or is it being explored?

INVESTMENT DIRECTOR REESE: The Long-Term Care Fund would be included as part of that exploration absolutely.

COMMITTEE MEMBER PACHECO: Okay. Very good then. That's all my answers -- questions, sorry. Excuse me. Thank you.

INVESTMENT DIRECTOR REESE: Thank you.

CHAIR RUBALCAVA: I see no more questions from the Committee.

No. I think we're all going to wait till we see the proposal.

So at this point, we'll go into public comment. I have Mary Brown, please.

MARY BROWN: As a long-term care policyholder, I appreciate the LTC agenda item and 70-page presentation on the program and fund status, but I'm very concerned about, one, deficiencies in the presentation, two, the fund's poor investment returns, and three, the staff's proposal to raise premium rates by 10 percent in each of the next two years.

First, the presentation is deficient. The LTC presentation reflects the conditions at the end of last June almost 12 months ago. While that time frame may be customary, the 70-page report and this agenda item

completely ignore the impact of the Wedding settlement -- Wedding lawsuit settlement approved less than a month later, and that impact was seismic costing the fund $744 million and resulting in 10,441 policyholders withdrawing from the program, a 10.5 reduction in enrollment.

The presentation details at length hypothetical impacts of changes to mortality, recovery rates, et cetera, while ignoring the elephant in the room, the impact of the Wedding settlement, which is already a reality.

At a minimum, providing a year old assessment without the larger context is ill-advised and it feels disingenuous. Before considering rate increases, the Board and the public need an updated assessment that reflects the pivotal Wedding settlement impacts that are now more than 10 months old.

Also, please note that the lapse section of the assessment, page 56, is particularly deficient. It claims to reflect data through 6-30-2023, but quote excludes data after 12-31-2020, and for any year in which premium rates increased. This feels like very selective data usage.

Two, dismal investment returns. During the 22-23 year, CalPERS earned 6.1 percent investment return for the Public Employees' Retirement Fund, which is great, but lost money on the Long-Term Care Fund for the same period.

How is that -- how does that happen, especially given the exceptional skill and experience of the CalPERS Investment staff. Is the Long-Term Care Fund a low investment priority, are there legal or policy obstacles to the fund utilizing a more successful investment portfolio, as was just mentioned by member Member Pacheco.

Before allowing poor investment returns to trigger rate hike discussions, it's incumbent on this Board to focus on removing all impediments to successful investment of this fund's assets.

Three, as just mentioned, a 10 percent annual premium increase is huge. Since I enrolled, the cost of my inflation protected LTC premiums has increased from 0.8 percent of my gross income to currently 6.7 percent, as they have for most LTC policyholders. If our premiums continue to rise, especially by 10 percent per year, while our pensions increase by no more than two percent annually, we are sitting ducks as the LTC costs eat into our fixed income. High premiums will eventually force us to drop out of the LTC Program due to unaffordability just when we become the most likely to need it.

Beyond unfair, this feels intentional, akin to the shock-lapse tactics called out by the judge in the Wedding settlement. With 10 percent increases each year, I will pay 13 percent of my entire pension by the time --

for LTC costs by the time I reach age 70, and 30 percent of my income by the time I reach 81 percent, and 30 percent is cited as the upper limit on what people should spend for their housing.

Thank you.

CHAIR RUBALCAVA: Thank you very much. We also have a caller on this item.

STAFF SERVICES MANAGER I FORRER: Thank you, Mr. Chair. We have Bobby Roy. Go ahead, Bobby.

BOBBY ROY: Hello. Good afternoon, Committee members. My name is Bobby Roy. And I am a Long-Term Care Program enrollee.

I've been paying my long-term care policy in 2013, when I, at the age of 26, found myself a single only child, realized that I had nobody to take care of me, like I -- if I were to get sick the way that my mom, my grandmother, and uncle had me to take care of them under the IHSS program.

My initial premium then was $134.97 per month. Today, at the age of 45, not the 70 plus that Mr. Moulds talk about, pay $256.42 a month. And doing -- and doing some back of the envelop calculations, the proposed increases will raise my rates to $310.27 per month in a time when more people are more and more price sensitive due to growing inflation.

There is a huge concern for me that I will not be able to retain this long-term care policy due to the cost and that I'll have to disenroll, you know, and not fall under the sunk cost falacy, but realize that I had coverage while I could. But if I can no longer afford it, and I need to pay for other things, that I'll have to get rid of this. I know that I would not be the only one that would be facing this. And I think that this is a reality that we are potentially going into a death spiral with the Long-Term Care plan, unless some creative thinking is applied to this situation.

Thank you.

CHAIR RUBALCAVA: Thank you very much for your -- expressing your concern.

That concludes the public comment on this item.

So now, we'll go to the summary of Committee direction.

CHIEF HEALTH DIRECTOR MOULDS: Mr. Chair, I have two directions. The first is to provide regular Board updates on the implementation of the PPO, and in particular on the disruption mitigation efforts that are starting almost immediately. And the second is to bring the Board a discussion presumably involving outside experts of the changes, both through CMS and through the Inflation Reduction Act, that are impacting drug prices

with an eye towards looking at how we can rethink our drug benefit to better position ourselves going forward under those new changed rules.

CHAIR RUBALCAVA: Thank you, Mr. Moulds. That's what I have too.

Thank you. Now, we'll go into public comment. We have Tim Behrens.

TIM BEHRENS: Chairman Rubalcava, members of the Committee, Tim Behrens, California State Retirees. I want to start with a thanks to Don and the Health Care team at CalPERS for spending over an hour with us going over their proposals they made today to you all and tomorrow to the Board. It's a good first step that hasn't been done in the past, a month in advance from what's been done in the past. And it's going to help us a lot, and we're going to bombard Don with other crazy ideas that we can come up with in communicating with our members on the increase in the different things that we're talking about.

So I also have requested -- and I couldn't hear when Larry talksed whether he talked about AB 236, Holden, and asking the Committee and the Board to consider endorsing this. I'm not going to be here tomorrow, so I'm going to ask you today. AB 236 would require health plans and insurers to annually update their provider directors to ensure accuracy when patients seek care. This bill

would also protect enrollees and insured individuals who receive surprise bills after being provided inaccurate or misleading information contained in a health plan or policy provider directory.

So I'd like you all to take a look at that and consider it.

(Coughing.)

TIM BEHRENS: Excuse me.

ACO REACH, we talked about this last week at the stakeholders meeting and what I thought were just some kind of advertisements turned out that California is now being inundated with ACO REACH being implemented. So my question for CalPERS is what, if any, impact will this have on CalPERS and their interaction with Medicare and providing us with the Medicare statements that we get right now. I don't know that it will impact it at all, but it's a question.

Single risk pool, good idea. Go for it.

Long-Term Care increased by 10 percent, bad idea. You're talking about people in their sixties that still are hanging on to their long-term care plans, like the gentleman on the phone, and maybe the lady before him, on a fixed income, you can't do it. It's just not doable. People have held on to it, even though they had a chance to cash it out, because they're at an age when they're

probably going to be using it. And hopefully they can start using it before the 10 percent increase happens. But not a good idea. It's not -- it's going to be very painful for a lot of stakeholders.

Thank you.

CHAIR RUBALCAVA: And thank you, sir.

That concludes public comment and I call for -- this adjourns the meeting. Thank you, everybody.

(Thereupon California Public Employees' Retirement System, Pension and Health Benefits Committee open session meeting adjourned at 3:38 p.m.)

CERTIFICATE OF REPORTER

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

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