MEETING

STATE OF CALIFORNIA

PUBLIC EMPLOYEES' RETIREMENT SYSTEM

BOARD OF ADMINISTRATION

PENSION & HEALTH BENEFITS COMMITTEE

OPEN SESSION

CALIFORNIA PUBLIC EMPLOYEES' RETIREMENT SYSTEM

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LINCOLN PLAZA NORTH

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SACRAMENTO, CALIFORNIA

TUESDAY, SEPTEMBER 17, 2024

8:31 A.M.

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APPEARANCES

COMMITTEE MEMBERS:

Ramón Rubalcava, Chair

Kevin Palkki, Vice Chair

Malia Cohen, represented by Deborah Gallegos(Remote)

David Miller

Eraina Ortega, represented by Nicole Griffith

Jose Luis Pacheco

Theresa Taylor

Yvonne Walker

Mullissa Willette

BOARD MEMBERS:

Fiona Ma, represented by Frank Ruffino

Lisa Middleton

STAFF:

Marcie Frost, Chief Executive Officer

Matthew Jacobs, General Counsel

Kim Malm, Deputy Executive Officer

Donald Moulds, PhD, Chief Health Director

Fritzie Archuleta, Deputy Chief Actuary

Rob Jarzombek, Chief, Health Plan Research & Administration

Julia Logan, MD, Chief Clinical Director

APPEARANCES CONTINUED

ALSO PRESENT:

Christine Reese, Investment Director

Tim Behrens, California State Retirees

Marguerite Brown

Jerry Fountain, California State Retirees

J.J. Jelincic, Retired Public Employees Association

Paul Markovich, Blue Shield of California

Susanne Paradis, California State Retirees

Ami Parekh, MD, Included Health

Lois Quam, Blue Shield of California

Owen Tripp, Included Health

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PROCEEDINGS

CHAIR RUBALCAVA: Good morning, everybody. We're calling the -- to order the Pension and Health Benefits Committee. And can we have roll call, please.

BOARD CLERK ANDERSON: Ramón Rubalcava.

CHAIR RUBALCAVA: Present.

BOARD CLERK ANDERSON: Kevin Palkki?

VICE CHAIR PALKKI: Good morning.

BOARD CLERK ANDERSON: Malia Cohen?

David Miller?

Nicole Griffith for Eraina Ortega?

ACTING COMMITTEE MEMBER GRIFFITH: Good morning.

BOARD CLERK ANDERSON: Jose Luis Pacheco?

COMMITTEE MEMBER PACHECO: Present.

BOARD CLERK ANDERSON: Theresa Taylor?

COMMITTEE MEMBER TAYLOR: Here.

BOARD CLERK ANDERSON: Yvonne Walker?

Mullissa Willette?

COMMITTEE MEMBER WILLETTE: Here.

CHAIR RUBALCAVA: Thank you. We'll now have -- we will now recess into closed sessions for Items 1 through 4, from the closed session agenda.

Thank you.

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

(Thereupon the meeting recessed

into closed session.)
(Thereupon the meeting reconvened
open session.)
(On record: 9:47 a.m.)
CHAIR RUBALCAVA: Okay. Everybody, we're back in -- we're reconvening into open session. So I thank you for your patience. So we'll -- we will continue with the remainder of the open session agenda. We will begin with Item 6A, which is a time certain of 9:45 a.m.
Please call the roll.
BOARD CLERK ANDERSON: Ramón Rubalcava.
CHAIR RUBALCAVA: Present.
BOARD CLERK ANDERSON: Kevin Palkki.
VICE CHAIR PALKKI: Good morning
BOARD CLERK ORTEGA: Deborah Gallegos for Malia Cohen.
ACTING COMMITTEE MEMBER GALLEGOS: Present.
BOARD CLERK ANDERSON: David Miller.
COMMITTEE MEMBER MILLER: Here.
BOARD CLERK ANDERSON: Nicole Griffith for Eraina Ortega.
ACTING COMMITTEE MEMBER GRIFFITH: Good morning.
BOARD CLERK ANDERSON: Jose Luis Pacheco.
CHAIR RUBALCAVA: He should be back.
There he is.

Say "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: Okay. So now we're going to -- I need to do the attestation. Good morning, because we are not all present in the same room and Board members are participating from remote locations that are not 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 attest that, one, either they are alone, or two, if there are more -- if there are one or more persons present with them who are at least 18 years old and the nature of the Board's member's relationship to each person. At this time, I'd like to ask each remote Board member to verbally test accordingly. Please conduct the roll attestation.

BOARD CLERK ANDERSON: Deborah Gallegos.

ACTING COMMITTEE MEMBER GALLEGOS: I am alone.

CHAIR RUBALCAVA: Thank you.

So now, we'll kind continue to Item 6a, the

health plan spotlight and Blue Shield and Included Health.

Mr. Moulds.

CHIEF HEALTH DIRECTOR MOULDS: Good morning, Mr. Chair members of the Committee. Don Moulds with the CalPERS team. This is the third of our health plan spotlight series. And today, it's featuring Blue Shield of California and Included Health. We appreciate the Committee's flexibility with scheduling this, so all of our invited guests could participate in person.

As you know, Blue Shield administers the Access+ HMO and EPO plans, as well as the Trio HMO plan. Starting in 2025, Blue Shield will administer the two CalPERS Medicare supplemental products, and Blue Shield and Included Health will administer the two CalPERS Basic PPO plans. From Blue Shield, we'll hear today from Paul Markovich, their Chief Executive Officer and Lois Quam who is their new President. From Included Health, Owen Tripp, co-founder and Chief Executive Officer and Dr. Ami Parekh, Chief Health Officer will share with us a little bit about who Included Health are and how they will support our Basic PPO members.

So why don't I go ahead and turn it over to Paul and to Lois.

PAUL MARKOVICH: Thank you, Don. Mr. Chair, members of the Committee, I'm Paul Markovich, CEO of Blue

Shield of California. On behalf of our company, I want to thank you, the Board and the staff, for this opportunity to speak to you, but more importantly for being a long-time customer. I have been working for Blue Shield for more than 25 years. And for the majority of that time, I have been working directly with CalPERS. In fact, my first executive position at Blue Shield started in May of 2002, when I was asked to help manage the transition of 400,000 CalPERS members to Blue Shield of California.

Now, I'm sure you're all asking yourself how in the world did I get a job with that responsibility at the age of 18?

(Laughter).

PAUL MARKOVICH: But that's a Story for another time. For now, I'd like to introduce our new President Lois Quam.

LOIS QUAM: Thank you, Paul, and good morning, Mr. Chairman and members of the Committee. It's an honor to be here with you today. I'm Lois Quam. I'm the new President of Blue Shield of California. This is my fifth week in the role.

And the reasons I joined Blue Shield as President just a few weeks ago mirror, I believe, the reasons that you selected Blue Shield as your partner. Blue Shield is committed to providing the hard working people of

California with high quality and accessible health care in every zip code, and doing so in a way that reduces the cost of health care increases annually to less than three percent.

I want you to know that as I do my work, what's in my mind's eye is a blue and gray speckled Formica table in a kitchen corner in my childhood home. Health care premiums and deductibles were the topic of conversation at that Formica table. Could we make a needed but not essential car repair? Could we go on a summer vacation? Could I go to summer camp? And I'm the daughter of a Lutheran pastor. And in my father's congregation, I learned that the costs of an illness could be as damaging to the family as the illness itself.

You, at CalPERS, lead the nation in making these conversations better for working people. We know what it means that you've chosen us as your partner and thank you for the opportunity to be here with you today.

PAUL MARKOVICH: Thanks, Lois. If we could go to the next slide.

[SLIDE CHANGE]

PAUL MARKOVICH: One of the things we look for when we are working with any other organization is how aligned are we in defining success? When you have that alignment, almost anything is it possible and when you

don't, it's difficult to accomplish much. And we just put the slide up there to show what I think you probably already have a good sense of, which is there's a tremendously strong alignment between our missions and our philosophies in what we are trying to accomplish. Blue Shield of California is a non-profit plan that was founded in 1939. We have adopted a two percent pledge, which means, we give back to our customers in the community any net income that exceeds a two percent margin as a percentage of our revenue.

And you can see on this slide, there's a lot of overlapping language in terms of what we want to do. The terms that stands out for me is "transform". And I say that because there's a lot of organizations that will talk about how they want to make health care more affordable, and higher quality, and better service, and more equitable, but aren't necessarily willing or able to do the really hard things that are necessary to change the system as dramatically as it needs to get changed to get those results.

If we can go to the next slide.

[SLIDE CHANGE]

PAUL MARKOVICH: This is what we call our strategy on a page. When we say we're a non-profit and a mission-driven organization, it really starts with us and

why we're here. And the way we like to describe that is we're here to create a health care system that's worth of our family and friends and sustainably affordable for everyone. What we mean by that is God forbid one of your loved ones needs to use the medical system -- first of all, they can afford the insurance, and the copays and the deductibles to access that care. And then secondly, they get treated the way you'd want your loved ones to be treated at their time of greatest need. That's the standard that we hold ourselves to. That's what we call our guiding North Star. And we understand that there's a very big difference between the current reality and that aspiration.

But if we can go to the next slide, I think that's what distinguishes Blued Shield sealed from other health plan organizations and just health organizations in general.

[SLIDE CHANGE]

PAUL MARKOVICH: Angela Davis once said I am no longer accepting the things I cannot change. I am changing the things that I cannot accept. And if there's anything that distinguishes us, it's that we are willing to go do the hard things. We are willing to take on challenges and transform the system when what you will hear from a lot of others is all the explanations about

why it can't change, all the explanations about why health care has its own inflation rate that's different than every other inflation rate, for example.

And I'll talk more about some examples of this. There are some that are more nationally known. There's some that you lived and experienced with us directly, in terms of where -- what we're willing to do and where we're willing to go.

If we can -- if we can go to the next slide --

[SLIDE CHANGE]

PAUL MARKOVICH: -- I want to talk a little bit about the fact that, look, you all know that health care is not working. You don't need to -- me to tell you that it's too damn expensive, the quality and the service are too inconsistent, it's not an equitable system. You know that. We know that. What I think is important is that we believe that it is the way the system is currently constructed. It's a systemic output. It's systemic outcome. And therefore, if you're really going to get to more sustainable results that you -- that we like better on cost, on quality, on service and equity, we have to change the system itself. It is an irretrievably flawed system. And trying to incrementally improve it isn't going to get us there.

So if we go to the next slide, we can talk a

little bit about what we're doing.

[SLIDE CHANGE]

PAUL MARKOVICH: We forced ourselves to say what would a system that is worthy of our family and friends and sustainably affordable actually look like. Forget about how it works today. Don't start with how it works today. Start with a clean sheet of paper and figure out what it looks like. And that's what we forced ourselves to do. And there's a lot of things that need to look different than they do today, but they generally fall into four broad categories.

Number one, we need to digitize, simplify, and automate a system that is still using fax machines and CD ROMs. And to be clear, we will engage our members in whatever mode of communication they prefer. We're not going to require people to be technical wizards or have Wi-Fi in order to get the services that they deserve.

But I was doing -- I'm going to give away my age now, but I was doing, as a consultant, a staffing model for primary care physicians as a consultant in 1993, so over 30 years ago. And a full panel for a primary care physician in 1993 is actually slightly larger than it is today. In other words -- and physicians are working harder, and they're getting burned out. So here we are, we have a -- we had no internet back then that was broadly

available. We didn't have electronic medical records and primary care physicians weren't working as hard, but seeing 2000 or more physicians on average as a panel.

So what we need to do is we need to figure out how to make what is a system that isn't getting more productive. In fact, if anything, it's maybe getting a little less productive and figure out how to get it far more efficient and automated, and use that technical base to help personalize care. So that's number one.

Second, we need to tie a pay to value. We repeatedly see when you pay for more service, you get more services. When you pay for better quality, you're going to get better quality, and that is critical.

The third thing is we need to make sure we're truly personalizing health care, understanding where people are, understanding their holistic life and health situation, and figure out how to treat them like they're one of our loved ones, like they are family and friends.

And finally, the pharmacy distribution model is fundamentally flawed. There's eight players between the pharmacy manufacturer and the member and they take up about a third of the entire cost of the drug. And they all get paid more money when we sell and administer more expensive drugs. It is a structurally inflationary system. You may have heard we made some announcements on

this last year. We are launching a new system, a completely revamped system, in January.

So this hopefully gives you a sense of kind of the major categories of things that we're pursuing.

If we go to the next slide --

[SLIDE CHANGE]

PAUL MARKOVICH: -- what you'll see is that we're making progress on this already. We've -- it's not like we've just started. We've been working on this for years. But what I will say is this is hard. This is just not easy to do. And in particular, we need to have others, health care providers, take this journey with us. And not all of them are necessarily willing to take the journey. And so, where there's a tension point that we are committed to managing with this Board, staff, and the CalPERS constituents is when we have those challenges and when we face the potential of a termination of a provider because of those challenges, we need to be able to work that tension between making sure we're achieving our transformational goals and the goals you've asked us to sign up for, but ensuring that members are getting the access that they need and having the least disruption possible.

If you go to the next slide -- hopefully that gives you a sense --

[SLIDE CHANGE]

PAUL MARKOVICH: -- of like how we think about the world in general. I also wanted to just chat a little bit about what we're doing specifically.

We have two different HMO products for you. One is the Access+ HMO and EPO. We have been rapidly expanding this. In fact, we've expanded it. It started in 2002. We've expanded by 23 counties since then and we're now in 53 of 58 counties in the State of California. And despite that broad geographic footprint, this is still a pretty affordable product and probably the most affordable broad HMO that you have available to your members.

The other produce that we have, if we go to the next slide --

[SLIDE CHANGE]

PAUL MARKOVICH: -- is Trio. And that has been introduced -- got introduced in 2020, so it's been relatively more recent. But this is the plan where all of the providers in the network - we call it our Accountable Care Organization - are participating in it. So they are getting paid -- they are having their pay tied to value. They are much more, I would say, cost, quality, and service conscious because that is how they maximize -- effectively maximize their income in this product. And

what we have seen is it tends to perform better as a result.

It has also allowed us to expand into again some challenging and costly areas like Santa Barbara, Monterey, and Butte counties recently. And we are also filing and hoping for regulatory approval to get into Shasta County 1-1-2025. Again, these are not always easy places to do business and deliver affordable managed care product like this. But this is a part of what I was talking about before, where we're willing to do the hard things and go into difficult situations in order to achieve our mutual mission.

And finally, we are -- if you go to the next slide --

[SLIDE CHANGE]

PAUL MARKOVICH: -- we're very proud and excited about the prospect of serving your members in the PPO effective January 1st, 2025. We thank you for the confidence that you've displayed in us. We're humbled by it and we are excited at the opportunity of what's possible here. We're thinking about things in two phases. One is just the initial launch of this relationship and then secondly the longer term objectives for it.

My parents taught me that you never get a second chance to make a good first impression. And so the first

order of business for us is to make a good first impression effective January 1st. And that means we need a seamless onboarding experience. We want to have the best possible service model we can provide the members. We want to minimize any discontinuity that members will face by -- in two ways. The first is to make sure we are expanding our contracting to physicians that are in the incumbents network but not in ours. So we minimize the number of members that have to consider changing physicians.

And then secondly, we have -- we have a process that -- where we can be very personalized for the members -- the small numbers of members. And we're hoping of the 400,000 members that are out there, that we get down to approximately 3,000 that are in that situation by January 1st. We started out around 13,000. We're now at around 7,000 members who are in that situation. We're hoping to get down to the 3,000 by January 1st, which would be less than one percent of the population.

Then we want to have a highly personalized experience, where we reach out to them, we understand their circumstance. This is something we're going to work very closely with Include Health on and make sure that they are taken care of, and to administer the design process that CalPERS has put together for those members.

And then finally, of course, we want to make sure that we're hitting our cost, quality, and service targets, those ambitious targets that we put out there, including ultimately hitting a three percent cost trend in 2028.

And I just want to turn it over to Lois here to talk a little bit more about what we're up to on the PPO.

LOIS QUAM: Well, I wanted to really express my appreciation for our colleagues at Included Health, Robin Glass, Included's President and I have made a strong connection. And this partnership, as you designed it, is set to be a really powerful way for your members to be guided through the health care system and to engage with the Blue Shield PPO. So Owen and Ami were very pleased to be here with you today.

OWEN TRIPP: Thank you very much. Good morning, Mr. Speaker, members of the Committee. We are glad to be here from Included Health. And a warm thank you also to Don Moulds, his team, and all the people who've put in quite a bit of work to get us to the moment. This has been, as with all things CalPERS, an incredibly scientific, empathetic, and comprehensive study of both what is today and is possible for tomorrow.

And that's actually where I want to start. My name, as I said, is Owen Tripp. I'm the Chief Executive Officer of Included Health. I'm also its co-founder. And

so if you'll indulge me, I would like to just share that this is a very personal journey to this moment. It's a journey that started with a sick child, a belief that we could access to higher quality care, and that in doing that journey to higher quality care, we could prove something that I think we all believe up here, but has yet to be proven, which is add its best the American health care system is the very best. I would even venture to say the California health care system at its best is the very best, but most people do not know how to use it properly. And at their time of great illness, anxiety, and worry, we overwhelm them with words they do not understand. Most Americans have about 5,000 thousand vocabulary words total that they use. The medical vocabulary of a trained clinician in the United States is 11,000 words.

Right there, they're outgunned, they're outmatched. And what you're going to hear from us today, myself and Dr. Parekh, is a very simple bet, a bet on the quality of our system when you deliver care in a deeply personalized, comprehensive way. And when you can put that in conjunction with the products like what you just heard from Paul and Lois, now you're really cooking with gas, and you're once again in a position to lead, lead not just for California and the beneficiaries of CalPERS, but indeed, and I hope this isn't going too far, a model that

we think will have national respect and hopefully will be ultimately copied. It's my job to introduce you a little bit to Included Health. So if you could go to the next slide.

[SLIDE CHANGE]

OWEN TRIPP: I want to tell you a little bit, first on who we are. So you're going to hear us talk consistently about the member perspective. And it's pretty simple, all of us in this auditorium today have been or will be participants in the health care system. And so, as I talk, I'd like you to picture for yourself what that felt like the last time you went through that or perhaps you are today taking care of somebody else who's in the health care system, recently took care of somebody else in the health care system. And you know what that feels like.

What Included Health is doing through the things that you're going to hear about today is making sure that members have everything that they need to complete their journey. And by giving them access, answers, and advocacy, we use this system the way it ultimately can be used to better result financially, to better result clinically.

Today, we cover over 10 million members across the country. We operate for those members 24 by 7, 365.

These are the ice road truckers in California -- I'm sorry, in Alaska. These are people working on oil derricks at the moment. These are police, fire, municipal, around the country, airline pilots, their crews, et cetera. People who do not have a lot of time in their lives to just stop and work on their health care. Therefore, we have to be wherever they are, whenever they are, with whatever they need. And you're going to hear that as a consistent thing that both Ami and I talk about today.

Part of the reason we're able to do this, looking at that middle tile, is that we have taken a fully employed approach to our clinical staff. That means over a thousand clinicians on staff today. We like to consider ourselves the place where the most forward-leaning clinicians across the United States want to go. Indeed, for every one application that we select to work on our clinical staff, we receive 200. And compare that with what you know about the statistics today around physician burnout, and lack of physician coverage in rural counties, including some of the counties that this committee considers.

And we earn our members' trust by answering all of those questions, big and small, whenever, wherever they are. That has earned us an 88 percent member satisfaction

rate. We have also committed, through our contract and our contracting discussions with you, to make sure that we deliver incredible member satisfaction and that promote our scores across our business. It's not just because we want to do the right thing, although I think you'll find that we very much do. But because when we deliver that member satisfaction, when we deliver that net promoter score, our members come back to us. They rely on us. They trust us. They often describe to us this is the best thing I've ever experienced in health care. I didn't know it could work this way for us.

Next slide, please.

[SLIDE CHANGE]

OWEN TRIPP: My job on this slide is not actually to take you through everything we've done. What I'd like to demonstrate in our environment is that we are constantly working on the problem. I think what vexes all of us, and Paul, and Lois, and the Committee, and the teams that are in this auditorium today, we've all been working on health care for quite a long time. And I think all of us would agree that you have to do a comprehensive approach. And so what you see here is since the founding of the company a relentless approach on figuring out what the best next step is, how we provide innovation that redefines people's experience.

What I'm pleased to share with you is that in our conversations with CalPERS, it was clear also to the team, that this comprehensive approach was needed, and many of the innovations that you're going to see on this screen are going to soon be available to CalPERS members, if they're not already today. That lean -- that leans on a lot of things around how we reach out to people, how we create always on access to therapy, to primary care, to urgent care, as well as a one-of-a-kind system to help people navigate their network and the instructions, and the secret coded parts of the health care system as it is designed today.

You heard about some of the great network innovation from our partners at Blue Shield. Part of what we hope to reveal to each of our members is exactly how to use those things, how they're available to them, and how to make transitions, where necessary.

Next slide.

[SLIDE CHANGE]

OWEN TRIPP: Finally, before I turn it over to Dr. Parekh, I want to just share with you that none of this works without a whole lot of incentive alignment. And these are the things we've heard from you and these are the things that we're going to be working on with you, as well as true northern lights that guide our work every

day for all of our clients at Included Health.

First, improved member experience means we have to meet your needs every single day, whether you consider it a big issue or a small issue or we may consider it a bigger issue or a small issue. If it's confusing you and it's holding you back from great care, we have to work on that, and we have to work on it until we resolve the problem. And I think that's especially valuable, as we make an audacious change in expansion and strategy here, because you are going to have members who are going to be confused about what those transitions look like.

Second, this is a wonderful PPO plan and in a lot of ways it's the envy of everybody around the country. But I want to make sure that value is demonstrated to each of those members in their daily use of it, as well as the fiduciaries of the plan and all of you on the Committee. And in doing so, we want to make sure we hit those goals. Paul just showed you the slide. He gave you the progression that audacious and I think necessary goal in our country, not just in the state, of hitting a three percent trend in 2029.

We do that by eking out and using every piece of the benefit of the design today and making sure that each of our constituents and partners understands how that's going to work.

And finally, we have aligned through our work together on what quality ultimately looks like. It's built on a strong foundation of HEDIS population health metrics, which look at the entire needs of your population, as well as very specific outcomes that I'm make excited about for very specific clinical conditions.

And I'm going to turn it over to Dr. Parekh right now who will have more to say about that topic.

DR. AMI PAREKH: Okay. Thank you, Owen and thank you Mr. Chair and members of the Board for carving out this time to really learn about the services that will be available to CalPERS members starting January 1st. It's an honor and a privilege to be here.

Next slide, please.

[SLIDE CHANGE]

DR. AMI PAREKH: I'm Ami Parekh. I use she/her pronouns. I'm an internal medicine physician and I've been on this journey with Owen for the last six years to raise the standard of health care for everyone everywhere. And I joined this journey, because I believe everyone deserves sort of what my family has, namely they have that doctor in their family that they can call upon when they need to advocate, they need answers, or they need to get access quickly. Every single person deserves that and that's wha we are built to do.

So I'm going to spend a little bit of time on this slide, because I think this is the slide where you'll really start to understand what it is that we are going to actually do for members starting January 1st.

So starting January 1st, 24/7, CalPERS members will be at -- be able to access our team and our technology. They do this in the modality of their choice. Some people like to call and have a conversation with one of our care coordinators. Other folks, and I probably put myself in this bucket, prefer chat, or text, because I can do it on the side of my desk while I'm engaging in work or taking care of my family. Some folks like to self-serve. They don't want talk to anyone. They don't want to pick up the phone. They want to be able to serve themselves through an app or a web experience. All of that will be available to CalPERS members.

So then what is it that they are availing themselves of? We take care of your mind, body, and wallet, everything in health care. I wish -- as a Doctor, I wish health care was just about clinical care sometimes, just make the person better, and not have to worry about the administrative hassle or the financial burden. But we know that is not the case. Most people complain about the administrative hassle of health care. That bill that they get, that they don't understand and they can't afford.

So, if you get one of those bills and you're a CalPERS member on January 1st, and you either think it's wrong or you just don't understand it, you can call, or chat, or engage with any of our team members to figure it out. You'll be able to have easy access to your out of -- your out-of-pocket expenses, your deductible. And if that bill is wrong, which unfortunately, often it is, we will help you -- we will be your advocate to decrease the cost of your out-of-pocket expenses.

So what else do we do? Sometimes -- and you have one of the best PPO products out there. You heard about it from Paul, and Lois, and Owen, but members don't know where to start. So what if I just need to find a primary care doctor? How do I find the best matched primary care doctor for me? Not the best matched primary care doctor for Owen, but for me. Even if we live in the zip code, we will be provided a different list, because we know that different providers are matched to different ones of us and we'll get better outcomes, if we find the right Providers, whether that's primary care, specialty care, or behavioral health.

Additionally, when you have that complex diagnosis, wouldn't it be nice to get access to the top expert in the country to make sure that that diagnosis is correct and you're on the right treatment plan? We know

that it takes about 17 years to go from evidence to community practice. Our job is to decrease that timeline, so that when you get that cancer diagnosis, we can get you an expert medical opinion, get you on the right track. We change diagnosis about 10 percent of the time and treatment plans about 60 percent of the time through these expert medical opinions.

And lastly, if you're one of those members who has a lot of needs, you were recently hospitalized, you have a few chronic conditions, we have a high touch care management program that will help walk you through and coordinate your care with a multi-disciplinary team.

The best PPO networks in the nation still struggle in a few areas, specifically behavioral health care access, primary care access, and having access when you need it, if it's 3 a.m. in the morning, overnight with your kid, or over the weekend when you fall ill, because you always fall ill on the weekends when nobody is available. So that's why we have built supplement virtual care services, so that we can get you into a behavioral health therapist or psychiatrist within a week.

Similarly, with primary care, we'll get you in within a week. And for those overnight events, those weekend events that just happened to all of us, we can mostly see you in 10 minutes. Those wrap-around services

on top of a PPO plan will drive outcomes that matter. This is how we get to more equitable, higher quality, and more affordable care.

Next slide.

[SLIDE CHANGE]

DR. AMI PAREKH: So I'm going to put this in this -- a member journey. This is an actual patient of ours. And the thing is, like Owen shared, there's millions of these stories, but I wanted to bring it to life for you through one particular one.

So this is a 50-uear old gentleman. He actually had a history of Kidney transplant. He was pre-diabetic and had hypertension. He also ends up being positive for anxiety and depression in screening. He, unfortunately, hadn't seen a doctor in two years, despite having all of these chronic conditions, not because he didn't care about his own health, not because he didn't want to be healthy, but because he had no car, so couldn't get to appointments, and because he just sort of frustrated, I guess would be the word to use, with the hassles of trying to get in.

So he got a communication from our client that Included Health, virtual primary care was available and decided, hey, this seems pretty ease. I just have to kind of click a button to make it happen. And started on his

journey with us.

Bad clinicians ordered a number of labs, just basic things, Hemoglobin A1C, glucose levels, chemistry panels. And unfortunately, the results came back really within an emergent set of result. His glucose was above 400. His hemoglobin A17 was above 15 percent. These are dangerous levels. And we had to send him to the emergency room. Not something we like to do, but when it's the right thing for the member, the right thing to do.

He got to the ER, his glucose was over 700 actually in the emergency room. And he was admitted for acute management of diabetic ketoacidosis. We followed him through this journey. When he came out of the hospital, you need a lot of things when you come out of the hospital. Owen was talking about for those of you carrying for members in the hospital right now, I have a family member in the hospital. It is complicated stuff trying to get someone on the right meds, at the right time, get he ride appointment set up after hospitalization. We did all that for this member. We got him a nephrologist, an endocrinologist, and obviously follow up with your primary care doctor. He also saw an Included Health therapist and a psychiatrist for the behavioral health aspects of all of this.

And then it turns out, he also needed that

transportation. So he took advantage of a partnership we have with Uber, as well as local transportation offerings to make it so that he couldn't make it to his appointments, and seven months later -- and again, these are very long longitundinal journeys. His hemoglobin is under control, under seven percent -- hemoglobin A1C, his hypertension is under control, and he is actually in a much better position for his health. And you can see how this is both going to give more healthy days in his months, but also reduce the number -- the total cost of care for the purchaser of this plan, because he's not going to end up in the emergency room time and time again.

Next slide.

[SLIDE CHANGE]

DR. AMI PAREKH: So who does this? This is the time where I get to smile, because this is one of the best teams in health care. We have over a thousand clinicians as Owen described. They have, on average, over 15 years of experience. They come to work for us, because they want to work in a system that works better. They are supported by a multi-disciplined -- multi-disciplinary team of social workers, pharmacists, dieticians. We talked about the behavioral health team, but also record specialists. It's really hard to get all your records in one place, if you're a member. So just having someone

help you do that, takes a lot of burden off the member and the clinician.

And again, we have the technology to support this team. And that was one of the reasons I joined Included from the traditional health care system, because I actually wanted technology to make health care better. And so using data, science, and technology bringing that to the member.

Next slide.

[SLIDE CHANGE]

DR. AMI PAREKH: So with that, again, we are truly honored to be here with Blue Shield and the CalPERS team to sort of change the way Basic PPO members are going to receive care starting January 1st, 2025. This is going to lead to better outcomes, lower total cost of care, and a better member experience, hopefully one that we want for all of our loved ones and anyone we know.

Thank you.

CHAIR RUBALCAVA: Thank you. We have questions from the Committee. So we'll start with Trustee Mullissa Willette.

COMMITTEE MEMBER WILLETTE: All right. Thank you, everyone, for the presentation and the information, and the personal experiences that you brought to our Board room here. I have two questions for Included Health. And

I'm going to ask them both first, because I think the answers are probably going to be similar or off of each other. First, I'm wondering how can you make sure that you are providing culturally competent services for the diverse members across various cultural and ethnic backgrounds that we have here at CalPERS. And then also similarly, what metrics or benchmarks do you use to evaluate the effectiveness of the cultural competent -- culturally competent services and their impact on health equities. And then if we can -- you know, how do those results then drive continuous improvement efforts?

DR. AMI PAREKH: I'll start and Owen will chime in as -- afterwards. I, first of all, wanted to appreciate the leadership CalPERS has shown along these lines. We've had some great meetings with Lisa Albers and Adrienne from the CalPERS team as we think about driving towards more health equity for the CalPERS members.

At Included, we think of a few things. First, we think about choice. So if you are a member looking at -- looking for a psychiatrist or a therapist, we want to make sure that you have a lot of options, so that you can pick someone who is best matched to you. So that is one way we sort of make sure that people have choice in the person that they want to receive care from clinically.

Second, we want to make sure that we're available

in all languages. So we do use a translation service that translates into every language that is spoken in America or across the world. It's called Volatia. And we do -- all of our services can be translated, whether that's by phone or on chat as well.

In terms of measurement, we actually do ask all of our members on registration for their race, ethnicity, and language preferences, as well as their sexual orientation gender identity. This allows us to both call them by their appropriate pronounce or their names that they would be preferred to be called by when we are treating them directly, but also, to your question, allows us to measure the impact of our services and make sure that we are driving equity as we get to outcomes. And so we have recently shown that people are using virtual services in an equitable way, meaning people who are historically marginalized from traditional health care actually use virtual services at higher rates, because there are fewer barriers to that access. And over time, we hope to show that outcomes such as diabetes screening, healthy days, all of those are also being driven equitably.

OWEN TRIPP: I just want to add and share my appreciation both for the leadership and the question today, that we also do this on the provider side of it.

So providers, through no fault of their own, are not trained in all things, in all conditions and needs of all populations today, this leads to people who opt out of care entirely, which is a really bad outcome to state the obvious. And so we're constantly reviewing and using our own screening algorithmic technologies to understand where providers are treating patients today and how well connected they are to those patient panels to better inform the next recommendation for somebody who's looking for a doctor who's going to show that cultural competence.

DR. AMI PAREKH: And I should have mentioned this, our providers are all required to do implicit bias training as well, to make sure that our own providers have the training they need to provide appropriate care to everyone.

COMMITTEE MEMBER WILLETTE: Thank you. And then the other question I just have is the two words that we're hear -- or the two letters that we're hearing more and more, AI. What is the future of the impact of AI to Included Health or where do you see it going?

OWEN TRIPP: I think artificial intelligence and other machine-learning technologies have tremendous potential to make our system more efficient and faster for members who need care. But ultimately, it is our philosophy -- and we do use this technologies for very

specific reasons, but ultimately our philosophy is that great care is when a provider, and his, or her, or there patient are connected in a conversation that both meets mind, body, and wallet meets all those conditions together. So it's an "and" for us, not a substitute.

And I would say sort of on a personal prediction basis, while I think AI can help with a lot of the administrative parts of the health care journey, I don't think it is going to ever be an adequate replacement for the diagnostic and therapeutic care.

COMMITTEE MEMBER WILLETTE: Thank you. I have no other questions.

CHAIR RUBALCAVA: Thank you. Very good questions.

President Taylor, please.

COMMITTEE MEMBER TAYLOR: Thank you very much. And everyone, I appreciate the presentation. Very lap you are all here. And I've worked with Blue Shield, Paul, for a while. Every time we go to one of our educational forums, I get lots of folks over to talk to me about this stuff, because these impacts -- I represent State workers on the Board. I represent everybody, but my State workers, the first thing they notice out of their paycheck is their health care premiums, right? And it impacts our raises and everything. So we may get a three percent

raise and health care goes up and there goes that raise.

So these are very important conversations we need to have. And I appreciate that I'm hearing Blue Shield talk about some disruption here, about how we make this better, so that we're not having this medical inflation that's ten times higher than regular inflation. I mean, not lately, but, you know, it was at some point for a while, and double digit increases for our members who make a couple thousand a month. They can't afford it.

So I guess I want to start with the question on it's slide six, attachment two for Blue Shield. And I really love this slide, because it goes to bringing prices down. But what I want to know is how. So real time -- because I'm a Blue Shield user right now and I have not seen prior authorization that works in less that 10 seconds. So I'd love to hear how that's going to happen.

(Laughter).

PAUL MARKOVICH: Thank you. And that is not live yet.

(Laughter).

PAUL MARKOVICH: It has not been -- so if you haven't seen it, it's because it's not happening yet. I mean, the claims settled in less than 10 seconds, we have done on a pilot basis -- on very small piloted basis. So we can do this and we have physically done it, but not on

a broad scale.

COMMITTEE MEMBER TAYLOR: I'm sorry. I mean the prior authorization, like credit cards.

PAUL MARKOVICH: And the prior authorization, yes, that's the same thing. That one has -- yeah, we're probably a little bit ahead of ourselves. I think our announcement on that isn't supposed to be technically coming for another few weeks, but so --

COMMITTEE MEMBER TAYLOR: Whoops.

PAUL MARKOVICH: That's all right. No, we're the one that wrote it down, so it's not your fault.

(Laughter).

PAUL MARKOVICH: So, yes, you're -- what you're seeing is -- and we just announced the digital health records in June of this year and we will have about 50 percent of all the data for all members by the end of this year, and more than 80 percent -- closer to 90 percent, I think, by the end of next year. So what you're seeing are things that are either just being put in place or being put in place in pilots and will be scaling. So the fact that you haven't seen them yet isn't a hallucination on your part. It's just that it's scaling up. But the basic idea here is, I'll give you an example that's not there right now. We've been piloting artificial intelligence ambient dictation for physicians, where they can just have

a face-to-face normal conversation, and by the end of it, the application fills out all the clinical notes in the electronic medical record to a high degree of accuracy. And all they have to do is check it and then they're don't.

And the physicians that are using it right now are saving about two hours a day. And many of them are saying three more patients a day than they otherwise would see. So the idea here is when you get these things out there and you scale them up, you can take away major friction points, you can reduce administrative costs, you can increase provider capacity, that's what we're shooting for, but we are on -- in the early days.

COMMITTEE MEMBER TAYLOR: Which is wonderful, because this is still talking about some disruption that we hadn't thought about before, being creative about it. And I had written AI in there, because that's the only way I can think that this is going to work, because I can't see how you're going to do prior authorizations or claims settled without some sort of AI in this, right? But also the physicians, one of the problems we have with primary care physicians is they're overworked, which is we have so few of them now or we have a shortage, I should say.

And part of that overworked is all the charting they have to do after they see their patients, right? So

if you are alleviating that, not necessarily saying that they must see more patients, but maybe then they can feel like they have a normal work-life balance like everybody else deserves, and, you know, we don't lose them to, you know, something else entirely. So these are all great things that could answer some problems.

And then my other one was - I don't even know how you would do this - tie physician hospital and others' pay to quality, efficacy, and member satisfaction. So to keep it, I guess, competitive, a lot of our hospitals pay these wages, right? So how do you change that model?

PAUL MARKOVICH: Well, yes, I'd -- I'll start with something we've already been scaling, which is the primary care physician model and the basic -- we can provide more details offline, if it makes sense. But the basic structure is instead of paying you for each 15 minute visit or particular procedure that you do, we pay you a per member amount for each of your members and we pay a larger per member amount if you hit quality scores, if your members are more satisfied, and if you're more efficient on things like prescribing more generic drugs when they're appropriate.

So effectively, as a primary care physician, you're motivation is to keep your population as healthy and happy as possible. And when you do, like even if you

don't see them, you might see them virtually, you might respond to their email, you're still getting paid, and you're still getting paid for doing the right thing. In the case of hospitals, we would like to see the compensation model we have in our Trio product, or ACO, be basically universal. And that product right now again effectively compensates hospitals similarly on a per member basis, which means that they're getting paid something, whether the patient is in the hospital or not, and there are bonuses associated with quality and service similarly.

Obviously, their incentive structure is different than it is for a primary care physician, because they're providing different services, but the structure is basically the same. And so if you can pay hospitals to help people -- help keep people out of the hospital and help keep them healthy, then you're not trying to chase these higher labor costs, for example, by just having more services for people, and running more tests, and putting them through more scans, which is a lot of what we're seeing today. You're trying to figure out effectively the hospitals and the physicians get on the same side of the table with the member, with you, and with us, and we say how do we make this better? Because when we make this better, when we make it more efficient, higher quality,

better service for the patient, everyone gets rewarded.

COMMITTEE MEMBER TAYLOR: So I like that. I think I want to also talk about how a whole -- a whole member approach as well. I don't know if that's in here or you guys are considering that, but a lot of times, I hear from my folks and I hear all over the place when we talk about health care in general that our -- as a person, you go in, you go in for the one thing, and nobody connects the rest. Oh, you had this before, so maybe we ought to take a look at this and test for this too. It's not there. We're not seeing that kind of care any more. And your primary care physician for HMOs should be your point person for that, you would think, right? So they keep all that connecting tissue for the whole body and we're not seeing that. And I don't know -- in terms of quality, right? So -- and in addition, does that mean they need to see a patient longer, rather than just 15 minutes?

PAUL MARKOVICH: Right. Yes is the short answer to the last question. I didn't have a chance to talk much about the shared decision-making model. But what we are looking to move to is a model that was frankly introduced as a concept with Wennberg back in the '80s I think. But the basic idea is you get to know everything you can possibly know about that patient and everything there is

to know in the world about that patient's condition or conditions, and then based on the evidence, develop the different care options that they have and the potential pros and cons to each. And then you sit down and between the patient and their caregivers or their family members and the clinician, you make a decision about which way to go.

And so I use the simple example of a prostate cancer as a condition, where watchful waiting, chemotherapy, and surgery are all legitimate potential treatment options, but they carry different risks --

COMMITTEE MEMBER TAYLOR: Right.

PAUL MARKOVICH: -- potentially for the patient. So being able to lay that out and have them understand it. But to your point, in order to make this happen and happen personalized and happen at scale, you have to use technology. You have to have --

COMMITTEE MEMBER TAYLOR: Right.

PAUL MARKOVICH: -- that digital technology base. You have to use artificial intelligence in a very smart way. And you can't be -- it has to be transparent. You have to know what it's doing. It can be a black box. Humans have to be making actual clinical decisions. But right now, every thing there is for a primary care physician to know, just in terms of new research that

comes out every year, they could read full time 14 hours a day, 365 days a year, and not keep up with it.

COMMITTEE MEMBER TAYLOR: Oh, yeah.

PAUL MARKOVICH: And so -- and they're treating patients. So having technology help keep track of all of the new discoveries that out there in the world, and then what's applicable to that patient's particular circumstances is something that we're going to have to use technology to assist the physicians to play that role and be holistic and personalized.

COMMITTEE MEMBER TAYLOR: Thank you very much. And then last but least, I want to say the pharmacy distribution model, we were talking about that earlier. So I appreciate that you guys are working on this, because this is one of our largest cost drivers for everyone. So thank you very much.

PAUL MARKOVICH: Thank you.

CHAIR RUBALCAVA: Thank you, Ms. Taylor.

Next, we'll have Trustee Pacheco.

COMMITTEE MEMBER PACHECO: Yes. Thank you. Thank you, Mr. Markovich. Thank you, Ms. Quam. Thank you Mr. Tripp, and thank you, Dr. Parekh.

DR. AMI PAREKH: Parekh.

COMMITTEE MEMBER PACHECO: Thank you. So I've got my first question. I want to talk about the Blue

Shield in your slide there. And I think it was page 10 of your slide. You said that you want to provide -- your goal is to provide positive member experiences for the out-of-network exception program for the in-hospital -- in-hospital -- in-office visits for the first 12 months. Can you elaborate on that and your vision on how that's going to proceed?

PAUL MARKOVICH: Well, what we did is we worked very closely with CalPERS staff to develop the policies around this. And there's different categories that members can be eligible for. So, you're very familiar, I'm sure, with continuity of care.

COMMITTEE MEMBER PACHECO: Of course.

PAUL MARKOVICH: And we're applying the continuity of car rule. So there could be a member who's in the middle of a treatment -- so of the these, hopefully roughly 3,000 people, some of them may qualify for continuity of care. And therefore, they'll be covered under that policy. But for those that aren't covered under that policy, we've created a set of guidelines for allowing members to continue to see their physician, even if they're out of network, during that 2025, that first year. And I can't articulate all the details of that. We can certainly provide that to you off-line, but the basic idea is that we want to look at each one of these member's

personal circumstances, determine which of the programs that's been designed they're potentially eligible for, and proactively make sure they know that, not make them -- like get a mail -- something in the mail, and then if they don't sign up, well tough. Like we're going to -- we with Included Health. This is the royal "we", are going to be reaching out to these members, understanding their circumstances, and making sure they're applied to each of these programs. So again, there's a lot of details behind the programs, but that's effectively what I was referring to.

COMMITTEE MEMBER PACHECO: And I think that's a -- that's a great idea. I like the way that you're going to personalize this for these -- for these 3,000 individuals. And actually that leads me to the next question which I had, which is Included Health, which is on that process. And I was really fascinated by your -- one of your flagship programs which is the clinically led -- clinically led navigation program -- clinical navigation. And I wanted to -- if you could elaborate more on that and how that relates to the CalPERS Pod, which is the connection between the physician and the clinical coordinator, which I suspect is the clinical -- the clinic navigator.

DR. AMI PAREKH: Yeah, I'm happy to talk a little

bit of how we think about clinical navigation. So the CalPERS Pod is a group of trained care coordinators who are trained on CalPERS, in addition to everything health care. So they are trained in the details of the benefits design, the plan, exactly what's in Gold versus Platinum, exactly all of the additional benefits these members have outside of even the network. So that's the sort of non-clinical staff that supports CalPERS members.

They have a sister team in our clinical navigation Pod. These are RNs, NPs, PAs, physicians who can be that doctor in the family, so to speak, for CalPERS members. So a care coordinator will do a warm handoff often with a clinician, to say, hey, you know, they called about this bill, but really they're trying to figure out is surgery the right next step. We've got the bill part handled. Can you talk them through this? What are the things they need to think about? Maybe they need a physician -- a new type of specialist that they're not seeing today that we can get them in with high quality -- in their -- in their network a high quality match for them. Maybe they need an expert medical opinion.

So it's really that guidance that is provided by a clinician, in addition to sort of the care coordination and the advocacy piece of things. Does that help explain it a little bit?

COMMITTEE MEMBER PACHECO: Yeah. That's excellent. And you mentioned that it would be applicable -- and that particular use case is interesting, but what other use cases, what other indications?

DR. AMI PAREKH: There's so many. So, you know, again for Basic PPO members at CalPERS starting January 1st, they can call us for almost any kind of question. Like we get calls, hey, I got diagnosed, or me or my loved one got diagnosed with cancer. Can you help me understand what this means? And again, most of the questions will be both clinical and administrative. People kind of go back and forth. And so what we see is sometimes people start clinically. They just want to understand the diagnosis and if they're in the right hands. But then, the financial questions start coming. And so that's when we do that warm handoff to our billing specialist who -- you know, clinicians can't know everything. They already have a lot to know, but they can make sure that there's an expert there who can help with financial aspects of health care.

And so we see that transfer happen, well, about 40 percent of the time. And then the other way, which is you call in for a bill or for just to know if somebody is in network, we get that a lot. You call in sometimes just for an insurance card. If you're calling us for an

insurance card, you're about to go see a doctor, so there's something that's happening.

And so we see the other way happen, also about 35 percent of the time, namely you start with an administrative or financial need, but it actually turns out you need to talk to a clinician. And so those are how those -- that's why we put these teams together in an integrated fashion.

COMMITTEE MEMBER PACHECO: Excellent. And just a follow-up question on that is how do you plan to measure the outcomes or the success of these clinical navigation programs?

DR. AMI PAREKH: Yeah. And Owen should feel free to chime in. So we've partnered really close with the CalPERS team to identify total measures of success of the program. So one of the measures we're most excited about is called Healthy Days. We ask members, over the last 30 -- it's a CDC approved measure. We're not creating metrics. We ask members over the last 30 days how many have you been unhealthy, not able to sort of live your best life. Subtract it from 30, you get a number. We measure that over time. Our goal is to improve the healthy days of our population.

We've also aligned on qualms with the CalPERS team to make sure that we're just hitting the basic HEDIS

metrics, you know, and improving those for the population over time. And then ultimately, you all are holding us accountable to a total cost of care. So we know that over time, we have to make the population healthier and make costs more sustainable. And so that's going to be the real checks and balance at the end of the day.

COMMITTEE MEMBER PACHECO: I mean, I just want to say I'm actually pretty excited that you mentioned healthy days. I've never heard that and I just actually find that really, really cool.

DR. AMI PAREKH: I do too.

(Laughter).

OWEN TRIPP: It's actually the North Star metric of our company. So we go over everything we do to try towards driving more healthy days, both at the individual and population level. And back to Trustee Taylor's set of questions, if you think about needing somebody to connect all those pieces together, this is what we really want to do. And this -- these Pods are designed to not have a member have to figure out again when they're not feeling well, whether this is a billing question, an administrative question, a benefit design question, a clinical question, an access question. We really want to try to answer those things holistically. And that seems to be working, albeit it is a new model for members.

COMMITTEE MEMBER PACHECO: That's interesting. Well, thank you so much and I'm excited to learn more as we -- as we go through this process. Thank you.

CHAIR RUBALCAVA: Thank you.

Next, we have Mr. Kevin Palkki.

VICE CHAIR PALKKI: Thank you. Thank you, both, for your presentations. Without reiterating what my colleagues have already said, I appreciate the responses and the conversations about finding a balance between technology and that therapeutical care, because I know that holding somebody's hand is as health -- has health products to it as well.

But also, we hear a lot in the -- out in the news, out in the world with the employees that even though we're hearing that technology is creating cost savings, the question is where is that cost savings going. And when we see that -- we hear the cost savings and we see the premiums rise, we question where that cost savings is going. And so I hope and wish you both the best in finding that balance in where that cost savings is going, and hopefully that cost savings can start to be seen by the end user.

So those are just my comments and wish you all the best in the future here. So thank you.

CHAIR RUBALCAVA: Thank you.

Ms. Walker.

COMMITTEE MEMBER WALKER: Thank you. So I have a question -- I get asked this. I've been doing meetings and I've got -- I don't have a good answer for it, but how exactly do the two of you work together, because that -- people want to know that practical example, like, yay, it's great. We've got Included and everything they do it sounds great. Yeah, we have Blue Shield and we think they're great, but how do they work together and how does that not make it more for us to do than -- so just an example of how you guys work together would be --

PAUL MARKOVICH: Sure. I'm going to just focus on the model for Basic members as opposed to the Medicare members, because there are -- the same way there's differences in the benefits in the way they're paid, there's differences in our model for that, but let's just start with the Basic members.

COMMITTEE MEMBER WALKER: Okay.

PAUL MARKOVICH: The general idea is that when the member has anything that they have a question about, when they're wondering what's going on, their outreach, whether it's all the -- Ami talked about all of the different ways that they could contact them by phone, website, app, that Included Health is the front door.

COMMITTEE MEMBER WALKER: Okay.

PAUL MARKOVICH: That is where members go, and they ask questions, and they engage. That entire engagement model is being driven through Include Health. And the rationale for that is, as you've heard, they're not just telling you whether you're eligible for --

COMMITTEE MEMBER WALKER: Right.

PAUL MARKOVICH: -- members, they're helping you answer clinical questions, financial questions, and taking a very holistic view. And the expectation here is that that is going to drive not only a better service model, but better care.

So now at the same time, they don't contract with physicians and hospitals, they don't have a network. There's a whole series of obviously clinical things that need to happen in terms of managing that network. So, that is where Blue Shield of California comes into play. We have to price and process claims. We have to contract with providers. There's a whole set of functions, considering them middle and back office, as a consultant might say, in the sense that they aren't immediately visible to the member. They're visible if don't work, so we need to make sure that they work.

And there's going to be times that Included Health says, wow, I need to talk to someone from Blue Shield of California. I need to ask a more in-depth

question. And what we're doing is setting up the operation, so it's not the member that has to have different phone numbers to answer different questions or different websites to go to. We coordinate that on the back end. So that's the general -- and I don't know Owen or Ami, you'd add anything?

OWEN TRIPP: I think you said it beautifully. I would just add that if -- if a member has to ask that question, we probably failed them somehow, either individually or collectively. The same way that, you know, one of us might go use a credit care later today, we issue -- we have a card issuing bank and we have a Visa, or a Mastercard, or whatever we have. Those are different companies, seamlessly creating an experience to deliver it to you and to make that private payment secure and, et cetera.

So I agree with everything Paul said, we should be working together and are working together to make this come to life today.

COMMITTEE MEMBER WALKER: Don't read anything into the question. This is new, you know, people are going into it, and so they don't know. And so they're imagining different things. So I appreciate that, because it was a lot simpler than what I was saying, so I really appreciate that.

And then I know that we're in the early days of open enrollment. It started Monday, but has anything jumped out yet?

CHIEF HEALTH DIRECTOR MOULDS: So I'll let them answer this question -- or happy to have them answer this question. I'm also going to be providing a little bit of an update on the transition as well in my opening remarks, but it would be great for you guys to touch on it.

DR. AMI PAREKH: I can just start. So in good news, CalPERS members are calling us.

COMMITTEE MEMBER WALKER: Of course.

DR. AMI PAREKH: So we have started serving CalPERS members. We started last week and since yesterday serving with OE. And the call volume has increased and the chat volume has increased. Overall, the member satisfaction is higher than we had set as a baseline expectation with the CalPERS team and Blue Shield, given we knew how much change was going to hit the CalPERS members this season. Escalations are far below the one percent bar that we had expected. And so that's great to hear as well.

The primary concerns are not surprising.

COMMITTEE MEMBER WALKER: Right.

DR. AMI PAREKH: Network disruption, is the person going to be in network, help me think about

continuity of coverage. So as of right now, the places where we have prepared and expected escalations is sort of what's driving them. The nice thing has been, just to earlier question, we have an incredible partnership already set up with Blue Shield and with the CalPERS team. This team is meeting daily to make sure that escalations as they come in, they are getting handled and/or changing things nimbly. So when we learn that CalPERS members like to hear things a certain way, we change the script --

COMMITTEE MEMBER WALKER: Okay.

DR. AMI PAREKH: -- for our team. And so that sort of daily iteration and innovation is happening as well for CalPERS members today.

COMMITTEE MEMBER WALKER: Oh, that's wonderful.

PAUL MARKOVICH: And I just wanted to mention, so I talked about the model on the Basic members. For the Medicare members, because everything is running primary through the Centers for Medicare and Medicaid Services, that's all being done by Blue Shield of California. And so we set up or call center effective August 12th. We've fielded about 500 calls. And I would say, you know, so far, so good, in terms of the customer service and the engagement of members. We've also staffed I don't know how many open enrollment meetings, but it was a lot the last time I checked.

COMMITTEE MEMBER WALKER: Right.

PAUL MARKOVICH: Well into the dozens. So we've been full engaged and, you know, we feel like from everything we had laid out, it's going pretty well, but we don't take anything for granted.

COMMITTEE MEMBER WALKER: Right. Appreciate that. Thank you.

CHAIR RUBALCAVA: Thank you, Ms. Walker.

Any more comments from the Committee?

Okay. I want to thank for your presentation. It's very good to hear about the engagement that's already happening with the members. I think that's the key element is making sure our members are educated, aware what's happening, and we communicate with them.

I'll tell you about my first experience with Blue Shield in the City of Los Angeles, but that's another -- long time ago.

(Laughter).

CHAIR RUBALCAVA: Where communication was key, I think, and -- or lack of it and it's understanding. But thank you. Mr. -- Dr. -- Mr. Moulds, back to you then.

CHIEF HEALTH DIRECTOR MOULDS: I think that's it for this item. I appreciate the four of you joining us. As I mentioned, I'm going to be touching on the transition a little bit in my opening and we have members of both

teams sticking around in case there are specific questions that you had for them.

CHAIR RUBALCAVA: Okay. We do have public comment on this item.

CHIEF HEALTH DIRECTOR MOULDS: Yep.

CHAIR RUBALCAVA: So we'll call up Mr. J.J. Jelincic.

COMMITTEE MEMBER TAYLOR: Jelincic.

COMMITTEE MEMBER WALKER: Jelincic.

J.J. JELINCIC: You would be disappointed if I didn't say something. J.J. Jelincic, RPEA.

Most of our members are in Medicare. However, a significant number are in the Basic plans and we all have concerns about medical inflation. This is a good example of the problem when health characteristics do not count towards the risk adjustment.

Access is a high-cost plan, but you want people in high-cost plans and therefore you subsidize it. And I had a flier that I think got passed out. Access+ is $1,100 a month, but that's high, but you want people in it, so you have chosen to subsidize it, by 158 bucks.

On the other hand, there is Trio, which is a subset of Access. It's designed to have the low cost, efficient providers. And I will point out that when Blue Shield first brought this program to CalPERS, it was

actually rejected as being too new and too small. Since, it's become part of our program.

But if you look at it, the premium is 761, and -- but we don't want people in low-cost plans, so this Board decided to add $147 to the premium. If you subsidize high-cost plans and you hit low-cost plans with surcharges, you're going to get more of what you want. We have an IRS tax code that's thousands of pages long. It's not so much about raising money, as it is about encouraging behaviors. Charging more for things that we don't want to happen and giving tax breaks for what we do want to happen.

What this Board has said is we will give breaks to people who will sign up for the high-cost plans, because that's what we want, and we will punish the members who sign up for low-cost plans, because that is not what this Board wants. The basic problem is that you have ignored health care characteristics when you do your risk adjustment.

Thank you.

CHAIR RUBALCAVA: Thank you.

Thank you. All right. Final time. Thank you.

So now, we'll have to recess into closed session to continue with items -- closed session items 4 and 5. And I apologize for that, but we will -- we'll be resuming

and open we'll bring everybody back.

And we will take 10-minute break. Thank you.

(Off record: 10:58 a.m.)

(Thereupon a recess was taken.)

(Thereupon the meeting recessed into closed session.)

(Thereupon the meeting reconvened open session.)

(On record: 11:30 a.m.)

CHAIR RUBALCAVA: Good morning. We're going to resume with the open session and -- of the Pension and Health Benefits Committee. And we'll start with the executive report, item number 2, Don Moulds and Kim Malm, please.

DEPUTY EXECUTIVE OFFICER MALM: Good morning. Kim Malm, CalPERS team. Lot me start this morning by giving you an update on our Benefits Verification Project. As you know, in late March, we sent out 8,700 letters to our retirees asking them to verify that they should still receive benefits. We found 194 deaths with that project. The deaths were about half of them in California and the rest spread across 24 other states. The deaths resulted in close to $1.9 million of overpayments, of which we've collected 1.4 million of those overpayments.

In July, we began utilizing Socure as our death

verification vendor. We sent them a first file of 43,000 records. And they found 94 deaths that we were unaware of. We then sent them another test file of about 40,000 records of inactives and disabled dependents. And they found 78 additional deaths that we were unaware of. The Socure was -- or we sent Socure the full file in the beginning of August, so about 800,000 records. They found 136 more deaths. And that was about $1.6 million of overpayments. And we just began the collection efforts and we've collected a little over half of that.

So the bottom line for the benefit verification and death verification projects, we've found over 500 deaths and about $5 million worth of overpayments that we've collected over 3.3 million of so far. That number will continue to get higher as we continue with our collection efforts.

Next, I'll shift to -- let me just say though, it's been a lot of hard work for the team. And I just want to say thank you to them and all the work that they've done over the last few months to find these issues and resolve them.

Next, I'm going to shift and mention the Sacramento CalPERS Benefit Education Event that we had in July. We had almost 2,000 attendees over the two-day period. There was almost -- or this was the highest

attended CBEE that we've had since we resumed CBEEs back in Oakland in 2022. And it's the first time we've been back in Sacramento since 2019.

A new addition to the CBEEs this year was our power of attorney table. And we had -- it was very popular. We had about 160 people that filled out their power of attorney while they were there. And the overall satisfaction rate for the event was 97 percent. Our next CBEE will be held virtually, December 11th and 12th. And then we have another one in person March 7th and 8th next year in Visalia.

Typically, I give you a quick update on the retirees utilization of IVR, or the phone system, or myCalPERS in checking their warrants. So we've had over 6,500 retirees check their warrant via the phone system, the IVR, and we've had almost five -- or 50,000 that have checked their warrants via the myCalPERS app. The IVR was implemented almost a year ago and the myCalPERS app was just implemented in January, nine months ago. So I'm pretty pleased with the utilization of these new tools.

Don will mention open enrollment that started yesterday. I'd just ask for our members' patience as they call into the call center with questions. We received 7,200 calls yesterday with an average wait time of almost 11 minutes. And I appreciate all the hard work of the

call center and the entire management team that are taking calls during this time.

I'd like to close with a moment of personal privilege. Don Martinez, the Division Chief of Member Account Management Division is retiring this month and this is his last Board meeting. Don has served CalPERS for over 20 years, actually 23 years, and he's been an integral part of our CalPERS family. In his current role, he's expanded online service credit purchase features, implemented numerous process improvements, and enhanced communication amongst our members. These changes resulted in over 54,000 members paying $1 billion in service credit purchase balances over the past seven years. Don was committed to fostering the success of future leaders and served as a mentor in the Emerging Leader Ram for numerous years.

I'd like to wish Don all the best as he embarks on his new endeavors. And that concludes my comments. Happy to take two -- three questions.

Congratulations, Don.

(Applause).

CHAIR RUBALCAVA: Thank you, Ms. Malm. We do have comments and questions from the Committee. We'll start with Mr. Jose Luis Pacheco.

COMMITTEE MEMBER PACHECO: Yes. Thank you.

Thank you, Chairman Rubalcava. And thank you, Ms. Malm, for your comments. I just want to -- back to the first comment you mention with Socure and the file. I just want to understand -- I want to make sure that the process of transferring that file. Is that secure? Is it encrypted? Just if you can elaborate more on that.

DEPUTY EXECUTIVE OFFICER MALM: Well, I'm not IT, but yes it's secure and it's encrypted. And what we changed this year, and I believe I've mentioned it before, this time around is we used to send the full file every single month.

COMMITTEE MEMBER PACHECO: Right.

DEPUTY EXECUTIVE OFFICER MALM: And now we are just sending -- we just sent one -- the full file one time. And now we'll just be sending the additions or deletions to the role each month.

CHIEF EXECUTIVE OFFICER FROST: Ms. Malm and Mr. Pacheco, these -- this would be a better question in closed session.

CHAIR RUBALCAVA: Oh, sorry.

DEPUTY EXECUTIVE OFFICER MALM: I'm sorry.

CHIEF EXECUTIVE OFFICER FROST: You'll see when we go through our information security.

COMMITTEE MEMBER PACHECO: Sure. No problem. Thank you. Thank you.

CHIEF EXECUTIVE OFFICER FROST: Yeah, thank you.

COMMITTEE MEMBER PACHECO: Thank you so much. Appreciate it.

CHAIR RUBALCAVA: Thank you.

Mullissa Willette, Trustee.

COMMITTEE MEMBER WILLETTE: Thank you. Thank you for that information. I just wanted to take a moment of privilege to stay I got to visit the San Jose Regional Office again. I made my online, my CalPERS account appointment. And I want to shout-out to Maria for the warm welcome, Amanda and Whitney who witnessed my power of attorney, which is now up to date and in my account. So I just am really always pleased with the San Jose Regional Office every time I visit and really happy with David Rubio and his team over there. So thank you guys.

DEPUTY EXECUTIVE OFFICER MALM: Appreciate the feedback. Thank you.

CHAIR RUBALCAVA: Thank you.

And Mr. Kevin Palkki.

VICE CHAIR PALKKI: I, too, just want to share my thanks to you and your teams. I know that my predecessor would be very excited to hear the good news about the power of attorney form. And so thank you for the work on that as well. So thank you.

DEPUTY EXECUTIVE OFFICER MALM: Thank you.

CHAIR RUBALCAVA: Thank you very much and thank you for your years of service. Appreciate it.

Mr. Don Moulds.

CHIEF HEALTH DIRECTOR MOULDS: Great. Thank you, Mr. Chair. Just a few updates ahead of the agenda items that we'll be getting into later on today. First, I'd like to share that Rob Jarzombek, Danny Brown, and I had a quick, but I thought very successful, visit to Washington, D.C. on Wednesday and Thursday of last week. We met with staff from the Senate Health Committee, minority staff from the Health -- from the House Energy and Commerce Committee, and several of the California congressional delegation, including Senator Padilla and his health staff and staff from Senator Butler's office.

On the administration side, we met with Meena Seshamani who runs Medicare and Secretary Becerra's Chief Competition Officer, Stacy Sanders. Discussions focused on four areas of critical importance to CalPERS, high drug prices and pharmaceutical benefit manager reform, health care consolidation, primary care, and behavioral health.

It was a great opportunity to share these key concerns for CalPERS to follow up on a number of issues we've raised with Congress and the Biden administration in letters and past conversations, and to offer CalPERS as a resource for federal efforts.

Next, I'd like to remind members, I guess, Kim has already reminded members, but I will re-remind members that open enrollment started yesterday and runs for four weeks through October 11th. This is the annual time members can change their health plans, add, or remove dependents. All of the information a member needs to research plan choices and the 2025 premiums is available online in myCalPERS and on our website on the open enrollment pages.

We added even more communications this year to help ensure members are aware of all of the plan changes. Not only do we have expansions of some of our lower cost HMO plans, but we want to ensure that PERS Gold and Platinum members are well informed about the administrator change to Blue Shield and Included Health.

We all understand how important this PPO transition is and Blue Shield and Included Health along with our teams have been preparing for weeks and stand ready to assist members with their questions.

Just a reminder that Medicare supplemental members should contact Blue Shield directly and Basic PPO members should reach out to Included for questions, including to find out if your doctor is in-network.

We want members to explore the options and to shop health plans this open enrollment, take advantage of

the tools and resources available to you, and make the best choice for you and your family.

I'll turn next to an update on the implementation with Blue Shield and Included Health. CalPERS is working daily with both teams as well as with Anthem and OptumRx to ensure transitions to the new PPO products are as smooth as possible.

Let me share a couple of specific updates. The Included Health call center went live on September 9th and received 900 calls and 350 chats last week, and then received about the same number of calls just yesterday. As Ami mentioned in her presentation, as of the end of last week, the most common question is whether a member's provider will be in network for the new PPO. We're also getting a significant number of members calling in to receive more information about the continuity of care benefits that will be in place.

We're holding daily meetings with Included to identify key call themes. This is another thing that Ami touched on. So thank you for that, and opportunities to tailor communications to ensure members are getting the information they need. So far, more than three-quarters of CalPERS members are reporting being satisfied with the service they're getting. As our teams continue working together closely, we expect the member experience to only

improve.

As a reminder again, Blue Shield is the exclusive administrator on the -- on the Medicare side, so they are handling all of the calls for the two med supp plans. To date, they have received about 700 calls with a majority of members calling with questions about their benefits and provider availability.

There are a number of areas of focus with Blue Shield, but the one that is most critical is their progress contracting with the new providers that will be necessary to meet the ambitious targets they and we have with respect to continuity of network. Shield has done extensive provider outreach, is adding new practices each week, and is confident in their ability to reach the disruption closure targets for members. So far, their performance is consistent with projections that have them meeting those goals by January 1st, though those projections are dependent on large numbers of new providers being added to the network in the coming three months, so we are working closely with them, and both of us are monitoring closely to make sure things stay on track.

The priority signing up providers has been the rural 22 counties, where finding alternative providers is most challenging. They're working in every county to do

this, but those are the ones that are on the top of the priority list.

As a reminder, for the small percentage of members whose provider will not be in network come January 1st, we have strategies to support them. We talked a little bit about these, so I'll make this brief. The first is continuity of care for members who are ongoing -- who are undergoing treatment for certain conditions or have a scheduled surgery. The second is limited out-of-network exception for all PERS Platinum members, and PERS Gold members in specific areas. Here, Included Health is assisting members in understanding their options and helping them take any actions needed.

Finally, our grievance and appeals team is working directly with their counterparts at Blue Shield and Included Health to guarantee members get help -- the help they need and that members and employers are heard when an issue arises. We are pleased with the progress the teams have been making. Whenever we hit a bump, we are addressing it and we are learning from the experience. We're also using feedback to further refine our communications, online resources, and training for our teams, so that are members have the best experience possible. This is a big undertaking and we welcome questions and comments about how we can better meet the

needs of our members and employers.

Finally, I'd like to share a recent visit I took along with the rest of California's Health Care Affordability Board to Monterey County. In Monterey, I shared recent analysis done by the terrific CalPERS health team looking at health care prices across California and at Monterey prices in particular. Covered California presented similar data. And Chris Whaley, who worked with us a lot when he was at Rand and who is now at Brown University, presented new research on the California commercial health care market. We are happy to share that data at a future Board meeting or an education session. But the upshot is that we are still seeing extensive price variation across California, 85 -- 82, sorry, percent from the most to the least affordable county in California. In Monterey County, their hospitals in particular, is not getting any better.

What I feel compared to -- compelled to share though is that the Affordability Board spent several hours hearing from bartenders, and janitors, and numerous teachers, and numerous, numerous hotel housekeepers who have had their lives destroyed by excessive costs we are seeing down there. Fortunately, CalPERS members are shielded from the worst consequences we see from the excessive high health care prices in Monterey, but they,

too, are hurting, and our CalPERS statewide health insurance premiums are suffering as well.

We have to do better on this issue. We have to do better in Monterey. I look forward to talking more about this with you all in the coming months. That concludes my opening remarks.

CHAIR RUBALCAVA: Thank you, Mr. Moulds.

Do we have comments from the Committee?

Is that a question?

No, I suppose not, but I am interested in that data, if you could share it at some point, Mr. Moulds, on the -- from your Board --

CHIEF HEALTH DIRECTOR MOULDS: Absolutely. And I'll just -- just to add a little bit. So we've -- you all have seen our terrific -- the heatmap that we have put together and update regularly looking at price variation across California. We just finished an update reflecting the closeout of the 2023 data. So that's what I shared at Monterey. David Cowling heads, who our research shop, and his team also did some really terrific analysis differentiating across hospitals, professional services, and looked at particular procedures. So I can share, for example, that in San Diego, it costs about $10,000 for a regular delivery. In Monterey County, I believe that figure is about $26,000.

So it's really helpful to see it -- the data broken down in that way and to look at some of the differences as you get into particular procedures, especially as we work with our health plans in their efforts to get the strongest contracts possible.

CHAIR RUBALCAVA: Thank you very much.

We will now continue with the action consent items. Okay. I think we need a vote on this.

CHIEF EXECUTIVE OFFICER FROST: Mr. Rubalcava, I think Mr. Pacheco had a question.

CHAIR RUBALCAVA: Oh, sorry. Jose Luis Pacheco, please. Continue.

COMMITTEE MEMBER PACHECO: I just wanted -- it's more of a comment, but I wanted to just say thank you for going to Monterey. And I just want -- and bringing out -- bringing this information to that area. As a person from the Santa Cruz, Monterey, Bay Area, I know how important it is down there.

I just wanted to also ask you when you were listening to the bartenders, the janitors, and the -- and the hotel workers, could you share a story or anything that came out that was a theme that perhaps came out, so I could -- we can kind of see -- sense what's the -- what's going on.

CHIEF HEALTH DIRECTOR MOULDS: Yeah, I'm happy

to. As I mentioned, you know, we are primarily -- we are not hearing from CalPERS members. I hear from CalPERS members all the time, in Monterey. I know all of you. I hear from CalPERS members, but there were a lot of teachers, a lot of -- a lot of, as I mentioned, hotel workers. And for them, they are fully exposed to the costs in Monterey County, so their plans are priced just for Monterey County. We have the advantage of -- we socialize those costs across the entire state for the -- for the State employees and across three regions for our local governments.

The most common thing that I heard there was that prices have gotten so high -- I mean, you hear obviously that any raise gets eaten up plus, plus by health care cost increases. But the other thing that you hear is that costs have gotten so high that the plans down there, the teacher plans, and the -- and the plans that are purchased by the folks -- by the unions who are representing these workers have to make really hard choices and often involve significant deductibles. So I heard of $9,000 deductibles in some of those policies. That was part of the testimony. They're also excluding some of the hospitals, because the costs are so high.

And so what you hear from our people who are making a few thousand dollars a month have to go into one

of these hospitals and have bills coming out that are numbers that they can't afford and will be in a position of paying back for years. And these were stories, after stories, after stories about people talking about the worst decision they ever made was seeking care. And that is something that should never be in a nation that as wealthy as ours is. And it is -- it is -- it is so tightly woven with the high prices there, that that is the issue.

I talk about this all the time, but we have -- you know, we have a 30 plus percent spread between our Northern California and Southern California prices. It is everything to do with competition and we need to be doing everything we can to bring competition to these areas.

COMMITTEE MEMBER PACHECO: Thank you, Mr. Moulds, for your comments.

CHAIR RUBALCAVA: Thank you very much, Mr. Pacheco.

Now, we'll continue with the agenda. Do I have a motion to approve the June 11th meeting minutes?

VICE CHAIR PALKKI: (Raise hand).

CHAIR RUBALCAVA: Moved by Mr. Palkki.

Second?

COMMITTEE MEMBER MILLER: Second.

CHAIR RUBALCAVA: Second by Mr. Miller.

So that will be the order.

Do I have approval for the timed agenda?

CHAIR RUBALCAVA: We have to take a vote.

BOARD CLERK ANDERSON: Yeah.

CHAIR RUBALCAVA: We have to take a vote. Please take a 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: Nicole Griffith?

ACTING COMMITTEE MEMBER GRIFFITH: 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: Good. Now, we'll continue with the approval of the -- today's timed agenda.

COMMITTEE MEMBER MILLER: Move approval.

CHAIR RUBALCAVA: Mr. Miller moves approval.
COMMITTEE MEMBER PACHECO: (Hand raised).
CHAIR RUBALCAVA: Mr. Pacheco second.
And we'll have 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: Nicole Griffith?
ACTING COMMITTEE MEMBER GRIFFITH: 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. Thank you.
Now, we proceed to item number 4, information consent items. I have not received anything from anybody. So that's good.
The next item is the Long-Term Care Program

rates, which will be a substantive discussion, so we're going to hold that until after lunch. But if people want to -- people who have signed up for public comment -- oral presentations, public comment, we can take now, unless you signed up for Item 5a, of course.

So I have Mr. Tim Behrens followed by Susanne Paradis.

TIM BEHRENS: Which button? Oh, it's on

Chairman Rubalcava, members of the Committee, I just felt compelled sitting out in the audience and reading about two 10 percent increase in long-term care for all of our members that are on a fixed income, already facing barely getting buy and buying groceries, if there's not some other vehicle that CalPERS could come up with to reduce this anticipated 10 percent and then 10 percent the next year. My worst experience, when I go to chapter meetings all up and down Highway 99 and east into the gold country, is when I ask is there anybody here that's still on long-term care?

And I hope nobody answers, because when they do answer, it's a very, very sad story. And this is only adding insult to injury.

Thank you.

CHAIR RUBALCAVA: Thank you.

SUSANNE PARADIS: Hi. My name is Susanne Paradis

and I'm the California State Retiree's Director for District B, which includes Monterey County. I can cross out two paragraphs of what I was going to say, because Don Moulds was at that meeting and he just reported on it.

So, what I would now just like to say is that I remember in February 2024 when Kaiser's CEO Greg Adams recounted the difficulty that Kaiser is having breaking into Monterey County for its Senior Advantage members, because they have to go into the whole county to get approved by Medicare. So I hope the work continues to force a more competitive situation in Monterey County, where Kaiser can come in and help make health care in Monterey more competitive and bring costs down.

Thank you.

CHAIR RUBALCAVA: Thank you very much.

Thank you for your public comment. We will continue after lunch with the Long-Term Care Program item and people are free to also speak on that item.

So at this point, we'll take a break for lunch and we will come back at 12:45.

Thank you.

(Off record: 11:56 a.m.)

(Thereupon a lunch break was taken.)

AFTERNOON SESSION

(On record: 12:46 p.m.)

CHAIR RUBALCAVA: Good afternoon. Welcome back. We're going to resume the Pension and Health Benefits Committee open session. And the item before us is the Long-Term Care Program rates.

(Thereupon a slide presentation).

CHAIR RUBALCAVA: Don Moulds and Jared.

CHIEF HEALTH DIRECTOR MOULDS: Great. Thank you, Mr. Chair. Don Moulds, CalPERS team.

Yesterday, in the Investment Committee, the Investment Committee voted to approve an updated asset allocation as part of its ALM mid-cycle review. You were all there, of course, but for folks who are just tuning in today, we can report that the new portfolio is projected to both increase returns relative to the discount -- the current discount rate and to derisk the portfolio. So that is positive news for the Long-Term Care Program.

Typically, a mid-cycle review would focus on the asset side of the equation, evaluating updated capital market assumptions and potential changes to the portfolio. For the Long-Term Care Fund, the review the Board heard yesterday was more comprehensive and was expanded to bring together the eval -- and evaluate the assets, the liabilities, and propose rate increases that this

Committee will be taking up today.

Can you go ahead and advance the slide.

[SLIDE CHANGE]

CHIEF HEALTH DIRECTOR MOULDS: Thanks. Perfect.

As I mentioned yesterday, the CalPERS Long-Term Care Program is in its 30th year. It has approximately 80,000 policyholders and has paid long-term care benefits for about 41,000 policyholders since the program has been in existence. In 2020, the Board suspended open enrollment in the program due to plan premium volatility and uncertainty in the long-term care market.

Next slide, please.

[SLIDE CHANGE]

CHIEF HEALTH DIRECTOR MOULDS: The recommendation we are coming to you with today is that the Board approve two long-term care rate increases, a 10 percent increase in early 2025, and a second 10 percent rate increase in 2026. Per California law, for our 3,000 policyholders who own a partnership policy, the same total rate increase would be spread out over three years. This is the same rate increase proposal I first discussed with you back in June. And it assumes the asset allocation changes the Investment Committee recommended yesterday.

Our recommended rate increases are based on extensive analysis conducted by our actuarial team with

input and validation from external actuaries and other long-term care experts. As I noted yesterday, there are three main considerations that are contributing to the need to raise rates. The first is a material change to the projections of our enrollees' future long-term care needs. Since the last rate increase, both morbidity improvement rates and claim termination rates required an adjustment. These adjustments add to the projected costs of the program and thereby place upward pressure on our rates. The second factor that is contributing to the need to raise rates is worse than expected investment returns over the period of time between our last rate increase and the April valuation report.

Following a period of historic increase in interest rates, return on our investments of the Long-Term Care Fund significantly underperformed. For 2021 and 2022, investments in the Long-Term Care Fund realized a nearly 10 percent loss. And for '22 and '23, they realized a loss of six-tenths of one percent. As a reminder, the assumed rate of return on the portfolio is 4.75 percent.

The other main consideration behind the recommendation is that we are entering a period in the lifecycle of the Long-Term Care Fund where a high percentage of our policyholders are starting to transition

from premium payors or premium -- to claimants. We talked about this a good amount yesterday. As a reminder, our policyholders stop paying premiums when they become claimants. The average age in the program is now 78, which is about six years younger than the average age a policyholder starts to draw down their benefits.

This means that the number of policyholders who pay premiums is and will be rapidly shrinking, along with the reserves in the program that are used to pay for their long-term care. So in the future, if we need to adjust rates to account for changes in actuarial assumptions or because our investments do not perform as expected, rate increases will need to be much higher to replenish the fund to the same degree as the more modest rate increases we are considering now.

Potentially, we could find ourselves in a situation where those rates could be unaffordable for most policyholders. As we discussed yesterday, this last consideration warrants conservatism in our planning for the near- and long-term care -- I'm sorry, for the near- and long-term future of the program.

Next slide, please.

[SLIDE CHANGE]

CHIEF HEALTH DIRECTOR MOULDS: As of June 30th, the approximate margin in the Long-Term Care Program is

minus 27 percent. The margin is an estimate of how much premiums should change in order to bring the program back to fully funded. As Fritzie noted yesterday, in her presentation, by adopting the proposed two rate increases, the probability of needing another rate increase within five years goes down by about 20 percent.

More importantly, though, by adopting these rate increases, the size of that potential rate increase, if needed, would be much smaller, about 10 percent -- about a 10 percent rate increase instead of the nearly 50 percent rate increase without them. As I stated yesterday, the purpose of these rate increases is to ensure that we have sufficient funds to meet the needs of all of our policyholders now and in the future, but it is also critical that we avoid unaffordable rate increases. Unaffordable rate increases can force policyholders to surrend -- to have to surrender their policies or buy them down to the point where the benefit is insufficient to meet their needs.

The rate increases we are proposing today dramatically improve our ability to do both, pay for enrollee benefits well into the future and mitigate premium increases, so they can continue to afford their policies.

And the last slide, please.

[SLIDE CHANGE]

CHIEF HEALTH DIRECTOR MOULDS: Yesterday, I talked a little bit about our AgeAssured Program that was launched in May. It will help our policyholders live independently in their homes for longer, and in doing so, reduce program costs. I also want to remind you that we have recently issued an RFP for our Long-Term Care Program third-party administrator contract and we are hoping through that process to see both enhancements to the member experience and efficiencies we hope will reduce administrative costs.

But even as we continue to do what we can to keep the Long-Term Care Program both high quality and as efficient as possible, we also believe that we need to raise rates. I want to assure the Board and those listening that we do not take these recommended rate increases lightly. We are -- while they are significantly lower than the last two series of rate increases we've needed to adopt, we recognize that they will create hardship for some of our Long-Term Care Program enrollees.

Neither the proposed rate increase nor our premiums are out of sync with what we are seeing in the rest of the long-term care industry. The entire industry has been facing the same challenges that our program is currently facing. In many cases, we are seeing premium

increases that are significantly higher than the ones we are proposing today.

As I have noted, our approach is to increase -- to those increases is to make a modest adjustment in rates now to reduce the likelihood that we'll need to raise rates much more significantly in the future. Letters notice -- notifying policyholders of each rate increase will also include an option to avoid the rate increase by making actuarially equivalent adjustments to their benefits. And policyholders will be able to call our third-party administrator illumifin to customize those changes.

To sum up, the recommendation today is to approve two annual 10 percent rate increases. The first would be effective January 2025 and the second one-year later in 2026. The only exception is for the partnership plans, these plans are regulated, as I mentioned, by the California Department of Health Care Services. And by statute, any rate increase for them needs to be spread out over three years. Our approximately 3,000 partnership policyholders would see a 6.7 percent premium increase for three successive years also beginning in 2025.

I'll stop there. Happy to answer any questions. Fritzie and Christine are also here as well to answer questions.

CHAIR RUBALCAVA: Thank you, Don. The Committee does have questions. We'll start with President Taylor.

COMMITTEE MEMBER TAYLOR: Thank you.

CHAIR RUBALCAVA: Whoops. Hold on. Apologize for that.

COMMITTEE MEMBER TAYLOR: Thanks, Don, for your really good presentation. I just want to reiterate for our members what happens without the rate increase -- the two rate increases, what happens?

CHIEF HEALTH DIRECTOR MOULDS: So we contin -- we would continue to stand in a negative -- in a negative margin. The last calculation was a minus 27 percent. And it does really two things. One is puts us in jeopardy of -- higher jeopardy of needing to have rate increases in the near term, but also increases that magnitude of the -- the magnitude of those rate increases. So the -- so the calculation is the difference between a 10 percent rate increase and a 48 percent rate increase.

COMMITTEE MEMBER TAYLOR: Got it. Okay. Yeah -- that's.

CHIEF HEALTH DIRECTOR MOULDS: And those may not be needed, but those are -- those are not out of the realm of the possible. I think Fritzie's numbers was that there -- if we don't do the rate increases, there's about a 60 percent chance of having to do a rate increase and it

drops to closer to 40 percent, if we do the rate increases. So it's both the odds of needing to do one and the size of the rate increase if we have to do one.

COMMITTEE MEMBER TAYLOR: Then additionally, if -- since this is something that we've been doing on and off, right, we've had some really big rate increases. I want to make sure that we also highlight that we aren't the only ones that we have -- that has to do this. So I just want to make sure that our members who are long-term care receivers understand that the industry itself is going through this -- the same thing we are, and that it's tough. Long-term care is health care and health care is expensive. So thank you very much for your presentation.

CHAIR RUBALCAVA: Thank you for that clarifying question.

Mr. Palkki.

VICE CHAIR PALKKI: Thank you. Yeah, the same concern. But also just sort of thinking out of the box a little bit here, the -- with the talks of the Feds lowering rates, does that, in any way -- depending on the outcome of that, does that, in any way, change the actuarial probabilities or the assumed percentages?

CHIEF HEALTH DIRECTOR MOULDS: Sorry, I wasn't on and now I'm back on. I'm going to let Christine, if that's okay, answer that questions.

INVESTMENT DIRECTOR REESE: Yes. So it is expected that the Fed may reduce rates by a quarter point. A lot of that has already been priced into the market and we have seen the principal value of the long-term care portfolio go up through this quarter. If rates do continue to go down, we would continue to see that trend. I think what we come back to is that, you know, we're coming off of the two years that had -- it was a negative 10 percent and then a negative half a percent where, you know, not only did we -- those were negative, but we -- you know, the goal would be to make the four and three-quarters every year. So it's a -- it's a pretty big gap that we need to make up. So we're -- you know, we're making strides there. But I think that, you know, in terms of how that correlates to the rate increases, that's something that, you know, when we come back, you know, in a couple years with the next ALM, that's something that I think we would want to look at as we assess going forward. So I think it's a little too early to tell what the impact of those rate decreases would be.

VICE CHAIR PALKKI: But there would be a probability that if we approve the 10 and 10, that in five years from now that could be theoretically less than 10 percent, in the --

INVESTMENT DIRECTOR REESE: Theoretically, yes.

And I believe that that's something that we would want to look at. And, you know, if we're in a position where -- you know, it would be great to be in a position where not only do we not need to raise rates in the future, but we could also potentially continue to de-risk the portfolio. It just really all depends on kind of what the market gives us at least on the investment side.

VICE CHAIR PALKKI: Thank you.

INVESTMENT DIRECTOR REESE: You're welcome.

CHIEF HEALTH DIRECTOR MOULDS: Just to add to that. You know, as we -- we intend to be having this conversation with you regularly. And as we get into those potential future outcomes, you'll have decision points. You could derisk. You could conceivably return some of that to policyholders. There are all sorts of things -- you know, getting into low probabilities that we would get to that point in the portfolio, given the risk that we are seeing and the history of experience with the program, but all of those will be conversations with the Board.

VICE CHAIR PALKKI: Thank you. Thank you.

CHAIR RUBALCAVA: Thank you.

Mr. Rank Ruffino.

ACTING BOARD MEMBER RUFFINO: Thank you, Chairman Rubalcava. Don, you already mention this a little bit about the hardship during your presentation. I want to

come back on this idea of the impact that it's going to have to our policyholder. And specific to the hardship, are there any plans for financial assistance or more flexible payment option for those most affected? I note that you -- you mentioned something that is an alternate that we just heard about. And I would like to maybe you can provide a little more info on that as well.

CHIEF HEALTH DIRECTOR MOULDS: Yeah. So when we do a rate increase -- I'll start with the second part. When we do a rate increase, we also -- so we send notice to our members -- to the policyholders rather. And as part of that, we give them -- we calculate a downgrade option. So we basically take the percentage rate increase and we include a change to their benefit that is the equivalent of the rate increase. So they can forego the rate increase, but it requires making their policy less comprehensive.

For some individuals -- for many individuals, that's a -- you know, that would be a shortening of the duration. For some folks, folks with inflation protection, for example, it may make perfect sense. They may be giving up something that is significantly lower value for them. If you're -- if you're in your mid-eighties, looking at the inflation protection for example, it's much less valuable than it would be to you

if you were 40. So it may turn out to be less painful than the dollar equivalent of the rate increase. It just depends on the individual.

Individuals can also call into illumifin and they can work out something with illumifin. So for instance, you can call illumifin and say, hey, I can't afford a 10 percent rate increase, but I think -- you know, I get a COLA of three percent say, and so I'd like to have a three percent rate increase. And then they can make the adjustment with the remaining seven. They can also look at different options. So if one option isn't appealing, you can ask them to consider different configurations of the benefits, so that they -- the benefit overall is of maximal value to you, given your situation. So those are all considerations that go into that piece of this.

ACTING BOARD MEMBER RUFFINO: Yes. Thank you for going over these options, because it's going -- they're going to come in real handy for some of our folks. You know, they're -- that they're experiencing hardship.

And this next comment I recognize may be difficult. There may not be an answer, but do we know what's the expected impact of these additional increases on policyholder retention and potential lapses?

CHIEF HEALTH DIRECTOR MOULDS: So, no. -- or do we? We have lapsed -- sorry. The red button that turns

you on rather than turns you off is something that I'll need to get used to.

The -- we do. We don't -- at this rate -- at rates, it's not a high number. Again, you know, for a policyholder, we would anticipate that in lieu of giving up a policy, you would make an adjustment to the benefit structure. We're -- we would never encourage policyholders to give up their policies. They're an important safeguard. These folks have invested in these policies for, in most cases, many years, and they have a lot of value.

ACTING BOARD MEMBER RUFFINO: And lastly, and I know you kind of alluded during your presentation, but alternatives. Were there any alternatives options to rate increases that were considered, and if so, why we did not pursue them?

CHIEF HEALTH DIRECTOR MOULDS: Sure. Yeah, I'll say that there are a lot of options. One is -- one is increasing the probability that we're not able to pay off the -- you know, the policies in the long term, which is not a risk that -- I mean, our number one responsibility here is to ensure that there are adequate funds to pay for all of these policies. So that -- that's something we looked at and we measured the cost-benefit of the various -- yesterday, in the investment committee, we

talked about this with respect to different asset allocations, for example. We also looked at this with respect to premium increases. We looked at higher premium increases that would drop the likelihood of future rate increases even more, but also create more of a hardship with these rate increases.

This was the number that we landed on that balanced -- that best balanced all of those concerns that kept it in the realm of affordable. Again, these are not insignificant rate increases. We are -- I'm not happy to be bringing them to the Board today, but they are much more affordable than they've been in the fat -- in the past, and they stave off, we think, these very large rate increases that we've seen in the past.

ACTING BOARD MEMBER RUFFINO: And thank you for that. And finally, just -- I know the stakeholder communications and how we're going to communicate this is kind -- I know we have the best communication team on board, but I hope we have a strong process to communicate, you know, with both employers and employees, and -- so that we can explain, you know, the decision, its implications, and how -- you know, and the different options that you have outlined.

And finally, not just say not mea culpa on this, but, you know, in a way, this Board collectively, you

know, this is something that we inherited and it's been an issue, you know, from previous times. And I want to thank your team especially, you know, for working very diligently to try to make the best, you know, out of their circumstances. Thank you, Mr. Chairman

CHAIR RUBALCAVA: Thank you, Mr. Ruffino.

I just want to follow up with some of the discussion people had raised. And I know that we look at the long-term care liabilities annually. They're updated annually. And following up on the question Mr. Ruffino raised about the plan experience, how many people -- whatever action they take to adjust the rates, if they can, or some people may actually cancel their policies. So do -- you know, do we do that annually also to look at how many -- the plan experience of how many people are actually going to claims, and how many payers, the ratio, and how often -- would you just explain the process and how soon we'll know whether we are -- we're being successful with this rate increase?

DEPUTY CHIEF ACTUARY ARCHULETA: So yes. Fritzie Archuleta CalPERS team. Thank you for the question. Just a couple numbers from the last rate increase, just so you guys know. In 2021, we offered 110,000 policies the option -- or the rate increase. They were provided also downgrade offers. About 30,000 policies took us up on it

and as a consequence about 2,800 lapsed their policy. That was back in 2021 when they were facing the 52 percent rate increase.

In 2022, when they offered a 25 percent rate increase, again that was offered to now 96,000 policies because we had some lapse and go away. But they were provided downgrade offers, and about 18,000 took us up on it and 15,000 -- 1,500 lapsed their policies. So those were just numbers from the last rate increase.

And yes, you're absolutely correct, every year on June 30th, we take a look at the demographics of the plan and we look to see who lapsed, and who downgraded, and we take that all into account, when we estimate the liabilities each year. So you'll get that report again in April of 2025.

CHAIR RUBALCAVA: Thank you. This is a very serious item, but we do need to implement so we can go forward and still protect the benefit of our members as best we can. So I will entertain a motion to accept staff's recommendation.

COMMITTEE MEMBER TAYLOR: So moved.

CHAIR RUBALCAVA: So moved from Ms. Taylor.

VICE CHAIR PALKKI: Second.

CHAIR RUBALCAVA: Second by Mr. Palkki.

Oh, we have -- oh, sorry. We do have -- we

should have the public comment before we vote.

We'll start with Mr. Jerry Fountain.

JERRY FOUNTAIN: Good afternoon, Board members. It's a pleasure to have this opportunity to speak to you. As a CalPERS Board member, not in a long-term care program, looking at the numbers, the policyholders are getting less and the claimants are getting larger. And one of the reasons is the policyholders as a group is shrinking may be because of the rate increases. A thought would be to look at the claimants and their benefits and possibly do something similar to a deductible. On one hand, you may have to raise the policyholders by let's say four, or five, six percent, but you may up -- be able to offset the costs by a deductible, maybe of less, one or two percent, because the size of the claimant pool. So I think that's numbers that could be looked at as an alternative.

Thank you for this ability to speak with this Board. Thank you.

CHAIR RUBALCAVA: Thank you for your comments.

Tim Behrens. You're listed. You already spoke. You have a -- I think you signed up twice for 5a and 6d.

TIM BEHRENS: I'll start wearing earphones so I can hear.

(Laughter).

TIM BEHRENS: Tim Behrens, California State Retirees. Thank you, Chairman Rubalcava and Committee for listening.

Last week, at our stakeholders meeting, I brought up an issue that I had never run into before. One of my members was getting treatment from a surgeon. And after the treatment was done, the surgeon dropped out of the network, so she had to pay full price for the course of her -- the rest of the course of her treatment. And I was asking then, and I'll ask again today, if the CalPERS team that negotiates contracts for 2026, can maybe work in some kind of language that will safeguard that from happening to other members.

CHAIR RUBALCAVA: Thank you for bringing this concern to us.

TIM BEHRENS: Thank you.

CHAIR RUBALCAVA: I thin Mr. Moulds -- Don --

CHIEF HEALTH DIRECTOR MOULDS: So I'll just -- I know we don't generally respond, but because this is an important -- obviously important. That shouldn't -- that shouldn't happen. There are protections in place, both in our program, through the California Department of Managed Health Care providing continuity of care in situations that sound like that kind of situation. So Mr. Behrens, if you want to put us in touch -- if you're willing to put

us in touch with that person, we can work with --

TIM BEHRENS: I will be happy to.

CHIEF HEALTH DIRECTOR MOULDS: That be would great. Thank you.

CHAIR RUBALCAVA: Thank you, Don.

I have another member on the phone. They can go forward.

STAFF SERVICES MANAGER I FORRER: Yes, Mr. Chair. Yes, Mr. Chair. We have Marguerite Brown to speak to Item 5a.

MARGUERTIE BROWN: I'm Marguerite Brown, a long-term care policyholder. And I am upset with the staff and the Board's management of the LTC Program.

First, policyholders have not been provided adequate materials on the program's financial outlook. The lengthy LTC presentation provided in June of this year only reflected conditions as of June 2023, conveniently ignoring the impact of the Wedding lawsuit settlement approved a month after that. The settlement -- and the settlement impact was seismic, costing the program $744 million resulting in over 10,000 policyholders withdrawing from the program and 10.5 percent reduction in program enrollment. The staff presentation detailed several hypothetical impacts of various tweaks, the mortality and claim recovery rates, while fully ignoring the massive

impact of the Wedding settlement that was already a reality.

That omission has not been rectified. Before approving the proposed rate increases, this Board owes us an updated LTC program assessment that addresses possible rate impacts from the Wedding settlement, impacts that should have been evaluated by now. Otherwise, we're like the frog in the boiling pot where it's -- we're getting heated very slowly. We policyholders deserve to know now any information the staff knows or should know about the program's financial outlook due to the Wedding settlement.

Second, the dismal investment returns. During the 22-23 year, CalPERS earned 6.1 percent investment rate of return on the Public Employees' Retirement Fund, which is great, but lost money for the LTC Fund for the same period. How does that happen, especially given the exceptional skill and experience of the CalPERS Investment staff? It's hard not to believe that the LTC fund has been low-investment priority. Hopefully, based on the comments that Don Moulds was making today, that is in the process of changing.

Also, are there any legal or policy obstacles to the fund utilizing a more successful investment portfolio? Before adopting the rate increases to offset poor investment returns, the Board should focus on improving

impediments to successful investment of the fund's assets and ensuring there is a fully engaged fund investment management team.

Three, a 10 percent annual premium reduction -- a premium increase is huge. Since I first enrolled, the cost of my inflation protected long-term care premium has increased from 0.8 percent of my gross income to 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 LTC costs eat into our fixed incomes.

High premiums --

CHAIR RUBALCAVA: Ms. Brown, please sum it up.

Your time is up. Please sum it up.

MAGUERITE BROWN: Yes. So am asking -- yes -- the Board to limit annual increases to the premiums to no more than two percent for CalPERS retirees.

Thank you.

CHAIR RUBALCAVA: Thank you very much.

We have a motion on the floor. Can we call the vote, please.

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: Nicole Griffith?
ACTING COMMITTEE MEMBER GRIFFITH: 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: Thank you. So that concludes Item 6b.
Now, we'll go to -- I'm sorry, yeah, 6 -- I'm sorry 5a. Now, we'll go to 6b, because we already had 6a, which is a pharmacy benefits overview and Inflation Reduction Act.
(Thereupon a slide presentation).
CHAIR RUBALCAVA: Thank you.
CHIEF HEALTH DIRECTOR MOULDS: And, Mr. Chair, if it's okay, I will turn this over to Dr. Logan.
CHIEF CLINICAL DIRECTOR LOGAN: Thank you, Don. And good afternoon, Mr. Chair, and members of the

Committee.

[SLIDE CHANGE]

CHIEF CLINICAL DIRECTOR LOGAN: Julia Logan, Chief Clinical Director and CalPERS team member. I'm joined today by Rob Jarzombek who is here, because he has an extraordinary knowledge of the IRA, so he will be helping with questions, and Don as well, of course.

Here is our agenda for our session today. First, I'll do a review of what pharmacy benefit managers are, as well as talk a bit about the overall evolving pharmacy landscape here in the United States. Then we'll talk briefly about both State and federal legislative activities directed at the pharmacy industry, including the Inflation Reduction Act, or IRA, and their impacts to CalPERS. And finally, we'll review our current CalPERS pharmacy benefit and our future plans around pharmacy benefits.

[SLIDE CHANGE]

CHIEF CLINICAL DIRECTOR LOGAN: At CalPERS, as you well know, our strategic goal for help -- health is to provide exceptional health care to our members. Our members are at the center of everything we do and we work to ensure that they have access to equitable, high-quality, affordable health care, which includes both medical and pharmacy care.

[SLIDE CHANGE]

CHIEF CLINICAL DIRECTOR LOGAN: So what exactly are pharmacy benefit managers, or PBMs?

First, just a brief history. They play a major role in the provision of pharmacy services by acting as an intermediary between pharmacies, plan sponsors, drug manufacturers, and drug wholesalers. PBMs emerged about 50 years ago in response to demand for specialized management of prescription drug benefits. Over the decades, PBMs have greatly expanded their influence in the supply chain and now handle claims processing, formulary management, pharmacy networks, mail order pharmacy, and contracting with wholesalers and manufacturers.

As their role and their visibility have increased, PBMs have also come under increased scrutiny from policymakers. Their extensive horizontal integration, which is the merging of two PBMs to form a larger PBM, and vertical integration, which is the merging of a PBM with another related entity, such as pharmacy chains and insurers, have drawn even further scrutiny due to consolidation.

[SLIDE CHANGE]

CHIEF CLINICAL DIRECTOR LOGAN: Today, PBMs have several functions. Their primary responsibilities include price negotiation, network management, formulary

management, and utilization management. Many PBMs also operate their own mail order pharmacies. We'll talk briefly about each of these. PBMs negotiate drug prices with drug manufacturers and pharmacies on behalf of payers like us. When negotiating with a drug manufacturer. PBMs will frequently offer to place the manufacturer's drug in a lower tier on an insurance plan's formulary, making the drug more accessible to a wider range of patients. In return, the drug manufacturer will give the PBM a discount or a rebate on the drug price.

PBMs also build pharmacy networks for insureds and purchasers. And this includes retail pharmacies like Walgreens, or your local pharmacy, mail order pharmacy networks, and specialty medication pharmacies. They negotiate with individual pharmacies by offering a pharmacy a place in the plan's network, increasing the pharmacy's potential for business and returns. The PBM reimburses pharmacies then at a set amount for dispensing prescriptions. Another key PBM function is the development and maintenance of a drug formulary. The formulary specifies which drugs the PBM will cover. PBMs also establish utilization management protocols for certain drugs on their formulary. This includes things like prior authorization and step therapy requirements.

Finally, PBMs have played a major role in the

expansion of mail order pharmacies, which ship maintenance medications directly to patients' homes, as well as specialty pharmacies. Many large existing mail order and specialty pharmacies are tied to PBMs and these have become an even larger source of revenue for the vertically integrated PBMs.

[SLIDE CHANGE]

CHIEF CLINICAL DIRECTOR LOGAN: This slide is a simplified illustration of the extensive horizontal and vertical integration mentioned earlier, that have made PBMs so profitable. There are currently 70 PBMs operating in this country. However, the three largest PBMs, Express Scripts, CVS, and OptumRx control approximately 80 percent of the market. This means that 270 million people in this country get their prescriptions through these three PBMs. The largest six PBMs, which also include MedImpact, Prime and Magellan, and Humana collectively control approximately 96 percent of prescriptions in the U.S.

They have managed to do so by consolidating so many of the different entities in the pharmacy market, including insurers, PBMs, and specialty pharmacies to name a few. Optum, CVS Caremark, and Express Scripts are all owned by very large insurance companies. All three of those PBMs own their own specialty and mail order pharmacies. And CVS owns one of the three largest retail

pharmacy network in the U.S. This dizzying market makes it extraordinarily difficult to figure out how much medications truly cost for consumers and payers like us, and what exactly plans purchasers and members are paying.

[SLIDE CHANGE]

CHIEF CLINICAL DIRECTOR LOGAN: Beyond integration, PBMs profit in other ways. One way is based on health plans or purchasers paying PBMs for services directly by establishing an administrative fee contract. Another route is spread pricing, where health plan or purchaser pays a PBM an agreed upon price for each prescription that's filled and the PBM retains the difference between the health plan's price and the pharmacy's price.

PBMs also generate revenue by keeping portions of manufacturer rebates as a form of compensation, whether that is because they don't pass through the entire rebate or because they hold on to the rebate until it's time to pay the plan or purchaser at the end of the year or quarter, generating significant interest income.

Beyond these three major ways PBMs make money, there is concern about other ways PBMs could earn revenue from purchasers, such as various fees for providing us with our data, or increased payments to mail order or specialty pharmacies owned by the PBM.

[SLIDE CHANGE]

CHIEF CLINICAL DIRECTOR LOGAN: As you've heard throughout this presentation and likely read about in news recently, even on the front page of the New York Times, there are criticizing -- criticisms associated with PBMs. Because of this, there has been markedly increased national interest in addressing these problems via legislation. The Federal Trade Commission began investigating the top PBMs a few years ago. They subsequently released an interim report in July of this year claiming that these large PBMs are manipulating the market by steering patients towards more expensive drugs. And the high level of market consolidation raises concerns about limiting competition and has the potential for anti-competitive prices.

Federal law makers have also introduced about two dozen bills since last year, including at least five with bipartisan support. Several of have passed committees, but have yet to come to a vote by the broader House or Senate. The bills generally target broad areas, like regulating revenues by restricting PBM compensation from rebates and by restricting PBM use of spread pricing, creating accountability to plan sponsors, and finally conducting studies of impacts of vertical integration.

There have also been a few bills at the State

level. California has passed one law that requires PBMs under fully insured contracts to be regulated by the Department of Managed Health Care. Another proposed bill would require increased mandatory reporting for PBMs, as well as for pass-through pricing.

CalPERS, in various comment letters to federal agencies, has recommended that the federal government pursue policies that would require price transparency from the commercial health sector, including PBMs. We have long advocated for initiatives that are aimed at prohibiting tactics used by PBMs that increase drug costs, as well as strategies that drug manufacturers used to block or delay the market entry of lower cost generic drugs and biosimilar products.

One thing that this scrutiny has done is to open the door for smaller PBMs to gain some traction. These shawl innovator PBMs aim to disrupt the industry and challenge the big PBMs with new ways of managing the use and cost of drugs with greater transparency.

There are also disruptors, such as Mark Cuban, whose Cost Plus mail order pharmacy circumvents the PBMs at all and charges wholesale prices plus a markup.

[SLIDE CHANGE]

CHIEF CLINICAL DIRECTOR LOGAN: Okay. Now, to the Inflation Reduction Act, or the IRA, and its impacts

to our benefits. The IRA of 2022 will drive the largest changes to the Medicare prescription drug benefit, or Medicare Part D, since its creation. The intent of the IRA is to provide meaningful financial relief from millions of people with Medicare by expanding benefits, lowering drug costs, and strengthening and stabilizing the program for future years. It gradually phases in several key amendments between '22 -- 2022 and 2029, including federal negotiation of drug prices, a new cap on Part D member cost sharing, and penalties for manufacturers that raise prices faster than inflation. Overall, the law shifts most of the financial ability -- financial liability, rather, from Medicare to payers.

[SLIDE CHANGE]

CHIEF CLINICAL DIRECTOR LOGAN: Here's a high level timeline of some of the major changes enacted under the IRA. As most of you may have heard, starting in 2023, there were two major changes that impacted our member's cost sharing. Insulin costs were capped at $35 for a month's supply and recommended adult vaccines, including the shingles vaccine, are now available to people with Medicare Part D at no cost to them, both of which are very important and positive changes for our Medicare enrollees.

2024 saw a modification of the catastrophic phase of the Medicare prescription drug benefit, so that members

no longer have to pay any coinsurance or copays during that phase for covered drugs. The most significant changes from the IRA will begin next year and later with the Part D benefit redesign, which we'll get into detail on the next slide, but don't advance it quite yet. Sorry.

In 2026, the biggest change is that we will the maximum fair prices negotiated for the first 10 Medicare Part D drugs selected for negotiation go into effect. The impact of these new prices to the Medicare Program will be enormous in terms of money saved, though it will be less impactful for individual enrollees at least initially.

The 10 drugs selected for the first round include treatments for diabetes, blood clots, heart failure, inflammatory bowel disease, and blood cancers. According to CMS, and you may have heard this, Medicare would have saved $6 billion if the prices that CMS negotiated for these 10 drugs had been in effect last year, amounting to a net savings of 22 percent on these medications.

We're working on a very similar analysis to better understand how the negotiated prices could impact our members and our program. CMS will announce the next set of 15 Part D drugs selected for negotiations by February 1st of 2025 and announce maximum fair prices for these drugs in November of 2025.

CMS will continue to add both Part D and Part D

drugs in successive phases for a total of 80 drugs by 2030. It's uncertain how many Medicare beneficiaries will see lower out-of-pocket drug costs in any given year under the drug price negotiation program and the magnitude of potential savings, since both will depend, in part, on which drugs are subject to the negotiation process and the price reductions achieved.

In addition, whether Part D enrollees pay lower out-of-pocket costs for a given Part D selected drug will depend, in part, on whether they pay flat copayment amounts, as with our CalPERS Medicare members, or a coinsurance rate for the drug in their chosen Part D plan. And while the direct negotiation provisions apply solely to the Medicare population, the resetting of prices could have a profound effect on drug prices for the commercial market as well, potentially positive or negative.

Next slide, please.

[SLIDE CHANGE]

CHIEF CLINICAL DIRECTOR LOGAN: The first key changes for 2025 is to CMS's defined standard benefit design. This will result in CalPERS' members paying less out of pocket for their prescriptions and CalPERS plans paying more, and I'll tell you how it works. The IRA imposes a $2,000 maximum out-of-pocket cost for the member under the defined standard benefit design. CalPERS has a

plan design that the is richer than CMS's. Under the Part D redesign, the greater of the defined standard cost sharing and the actual member cost sharing will be used to determine when an individual has hit their $2,000 maximum out of pocket. The result is that some members will be considered to have hit the maximum out of pocket after paying considerably less than $2,000 resulting in the member paying less in 2025, even though CalPERS hasn't change its plan design.

Essentially, the new defined standard benefit allows plan-paid costs to count towards the member's $2,000 maximum out of pocket, reducing costs for members, but increasing them for plans like us. Additional changes include a decrease in government reinsurance or subsidy in a catastrophic phase. Rob already discussed this issue with you in prior Board meeting, so I won't go into detail here.

Finally, cost smoothing, or the ability of Medicare members to spread out their $2,000 in cost sharing evenly over 12 months, and drug price negotiations will continue to have impacts over the coming years. We don't expect cost smoothing to impact our CalPERS members -- Medicare members to a significant degree, given our lack of coinsurance and the very low copays for our pharmacy benefit. The net impact of all these changes is

to shift financial responsibility away from Medicare and more towards plans and purchasers.

This means that while members will pay less overall out of pocket, and Medicare will see savings as well, plan sponsors like CalPERS are absorbing more of those costs, which in turn may lead to higher premiums.

[SLIDE CHANGE]

CHIEF CLINICAL DIRECTOR LOGAN: Given this very complex pharmacy market, extensive pending legislation with uncertainty -- uncertain regulatory impacts and the very real changes in uncertainty associated with the IRA, let's talk specifically about our CalPERS pharmacy benefit, where we are now and where we'd like to be.

[SLIDE CHANGE]

CHIEF CLINICAL DIRECTOR LOGAN: Currently, our members receive medications through either the pharmacy benefit or through their medical providers under the medical benefit. Our outpatient pharmacy benefit is administered through a self-insured arrangement with OptumRx, which provides benefits to approximately 587,000 of our members, including 422,000 Basic members and 165,000 Medicare members.

[SLIDE CHANGE]

CHIEF CLINICAL DIRECTOR LOGAN: This slide illustrates our pharmacy spend over the years as well as

the total spend as a percent of premium over the last four years. As you can see, it's a lot of money and a very significant percentage of our overall per member, per month. We spent more than $11 billion to purchase health benefits on behalf of our members. Approximately 21 percent of this spend in 2023 was for outpatient prescription drugs alone, which represents a two percent increase from '22 to '23.

And I wanted to go over some of the factors contributing to the overall increase in spend, including increases in cost and utilizations of some very expensive medications. In 2023, 48 percent of CalPERS self-funded pharmacy spend of 1.2 billion was for specialty drugs. Yet, that specialty drugs amount accounted for only about two percent of total outpatient drug utilization. Of the roughly $600 million difference in drug spend between 2020 and 2023, about two-thirds can be explained by five therapeutic classes. The most significant impact is the GLP-1s for the treatment of diabetes. We saw more than $100 million increase, or about a 50 percent increase in utilization in this class of medications. Our trends appear to be on the high side, of course, but appear to be consistent with industry benchmarks.

Another significant driver is vaccines. We saw four-fold increases in vaccine costs, like COVID, RSV, and

Shingles over the past few years. Again, very high and this was slightly higher than industry benchmarks.

[SLIDE CHANGE]

CHIEF CLINICAL DIRECTOR LOGAN: Other drugs in our top five that contribute to these high costs are oncology drugs, other diabetes drugs called SGL2 inhibitors and biologic drugs like for psoriasis and inflammatory bowel disease.

Here, I'll briefly review our current outpatient pharmacy benefit structure under OptumRx. As a reminder, these are drugs that are self-administered or administered by a caregiver and received through your pharmacy. Medications are generally classified as being distributed in three major channels, which are depicted above, retail, mail order, and specialty. We have three tiers for our retail medications, generic, preferred branded medications, and non-preferred brand. CalPERS is somewhat unusual in the industry, in that we don't have a separate and costlier specialty tier. Most of our specialty medications fall into Tiers 2 and 3. It's not uncommon for many other purchasers or plans to have four our five tiers and to have a coinsurance, rather then a copay associated with a specialty tier.

[SLIDE CHANGE]

CHIEF CLINICAL DIRECTOR LOGAN: We're currently

approaching the end of an extended five-year contract with Optum. We've extended the original contract twice for a total of nine years ending in December of next year. Optum provides comprehensive pharmacy benefit services, including an independent pharmacy and therapeutics committee staffed by national experts, formulary and utilization management, claims adjudication, and rebate negotiation.

There are definite strengths to our current contract, including a hundred percent pass-through of rebates, acquisition pricing for mail order and specialty, so that there's no spread pricing for mail and specialty. We also know that we have best in industry pricing for outpatient drugs. And we know this, because we conduct an annual market check and have terms in our -- in our contract that ensure we get the best prices.

On the clinical side, we take an active role in managing our formulary. We review our formally twice a year to ensure that the best and most affordable medications are available to our members.

Looking forward to our next pharmacy benefit contract that starts in 2026, given the high specialty drug spend for a relatively small number of prescription claims, we're particularly interested in cost effective management of specialty medications, including a

biosimilar first approach and programs to address particularly high cost medications including gene and cell therapies.

[SLIDE CHANGE]

CHIEF CLINICAL DIRECTOR LOGAN: With an understanding of the evolving and complex pharmacy marketplace in mind, we're are assessing our options for a pharmacy benefits contract starting in January 1st of 2026 for our members currently served by our self-funded prescription drug benefit. Our approach to our 2026 to 2030 self-funded pharmacy benefits strategy builds on our strategic plan of improving health care quality, access, affordability, and equity. Integral to this effort is our desire to align our objectives with the financial and programmatic goals of the pharmacy vendor that we engage with for the coming years. Our three main objectives with our new contract are to foster affordability for CalPERS and our members, ensure access to safe and effective medications, and to ensure transparency of the terms and arrangements between CalPERS and our vendor. These objectives complement our continued commitment to ensuring member choice, safety, and access for medications

This concludes my presentation and we're very happy to answer questions.

CHAIR RUBALCAVA: Thank you, Dr. Logan.

Questions, Committee.

Oh, Mr. Miller.

COMMITTEE MEMBER MILLER: Yeah. Thanks for the presentation. I think it was very well organized, well presented, and very helpful. One of the things that I will mention this, when it comes to the pharmaceutical costs, and especially the impact of some of these newer -- and a perfect example these GLP-1s, I think they almost -- in almost -- it almost demands kind of a little deeper dive maybe educationally for us as a Board and also may benefit stakeholders, is that there's so many aspects of that, that has been impacting things. The cost, the prices, are kind of exemplary of just the whole system. But the shortages and the fact that these -- this class of drugs is used for multiple different things, and that there's a lot of prescribing kind of off label, and now these complications with compounding as an option has also impacted the availability pretty dramatically, in many cases.

I mean, some parts of the country, you can drive for hours and hours in any direction and not be able to fill your prescriptions if you're, for example, diabetic who's been prescribed one of these class of drugs. And it brings up the issues of the actual clinicians are often completely either unaware or there's nothing they can

really do about the situation, and they're trying to prescribe, but not really knowing what the impact will be when their patient tries to actually fill the prescription and can't, or just the differences between the different options and the costs, or now the availability potentially of some oral alternatives that aren't as effective, but are probably better than intermittent use of something that would be more effective but isn't routinely available.

The other thing is I don't know the extent to which we really understand how frequently and how severe the shortages have impact people's ability to actually get those prescriptions when they're prescribed and what that's done in terms of the actual costs of the actual experience.

I'll tell you from my personal standpoint, over the last year, there's been at least two months out of the year, here and there, where I was not able to fill those or to fill alternative prescriptions that, you know, my physicians were able to like scramble and try to get me something else. But even those, they write the prescription, you go to Rite Aid, and they say, oh, well, we don't know when we'll get it. Just stand by and wait, and wait, and maybe it will be two weeks late, maybe it will be a month late, maybe we'll just tell you ask your

doctor to try to prescribe an alternative that might be more available.

So I think the -- we can anticipate that as the capacity, or as the supply chain issues get resolved, we'll probably see more usage and increasing costs of that, as people are actually able to fill their prescriptions, let alone have more comfort from the physicians in being able to prescribe them with confidence. So that's about it from there.

CHIEF CLINICAL DIRECTOR LOGAN: Yeah. If I could just -- I hear you certainly. I mean, supply shortages are something that as -- clinicians are often blind to that. They don't necessarily see that until they hear from their patients that they can't get a prescription filled, and that can be very frustrating obviously and challenging clinically for the patient as well.

I would say that GLP-1s, there is light at the end of the tunnel from what I've been reading and hearing in terms of shortages. That being said, I think we'll probably see shortages for other classes of drugs and other types of GLP-1s. So it's something that needs to be addressed in the short and long term.

CHAIR RUBALCAVA: Thank you, Dr. Logan. We have Mr. Frank Ruffino.

ACTING BOARD MEMBER RUFFINO: Am I on?

Oh. Thank you, Chairman Rubalcava.

And I want to start off by thanking you, Dr. Logan for this incredible presentation. I feel like I -- thank, God, I don't have to take a test afterwards to remember.

(Laughter).

ACTING BOARD MEMBER RUFFINO: But I definitely -- it's a study guide that needs to be read, and read, and to sink in. But -- and just as equally important, thank you to the entire team for your advocacy and the relator -- the letter writing campaign that you mentioned, you know, all the several letters. Thank you so much for doing that, and -- you know, and to monitor all these proposed federal and State regulation impacting, you know, the pharmacy market. As you said, it's very complex to navigate.

And one, don't be shy to ask the stakeholders, and some of us on this dais, to supplement, if needed, and be engaged and involved in this advocacy process, because it's -- that could be helpful at times. I know my principal, you know, the State Treasurer supports all your advocacy and your initiative.

That said, a quick question, back to the impact of the Inflation Reduction Act and cost. So given the Inflation Reduction Act Part D redesign that you mentioned

in your presentation and the shift of financial liability from Medicare to payers, I'm just curious, what cost implications are expected for CalPERS, and particularly for our Medicare members?

CHIEF HEALTH DIRECTOR MOULDS: Yeah. So that's a great question. The short answer is we think that we've seen the bulk of them in this last -- in this last premium -- in the premium for 2025. It is entirely possible that they can continue making probably more micro-level adjustments in the formula that they use to supplement the costs of the -- of the -- of the payer community and the plans, but we don't know, and we won't know.

You know, we've shared the experience we have with CMS, so they're aware, but they also are trying to doing a couple of things. One is create an incentive structure to reward good plan designs in the drug space and certainly these do that. And the other one is the main -- to maintain the integrity of the Medicare Trust Fund, which, of course, is in all of our interests, because long term, we need it to be there because it is a primary payer for the health care benefits for our members who are over 65 and for members facing disabilities.

CHAIR RUBALCAVA: Thank you.

ACTING BOARD MEMBER RUFFINO: I have a follow-up,

Mr. Chair. Oh, no, please, Dr. Logan

CHIEF CLINICAL DIRECTOR LOGAN: And if I could just add, I think two of the really important pieces of the legislation are the negotiation of drug prices and what that will do, maybe not in the short term, but in the long term, for our Medicare members and for commercial drug prices overall, which would impact our Basic members. Another thing I think that may decrease prices overall is the penalties for raising prices on drugs faster than inflation. There was a KFF article that said half of all drugs covered by Medicare had list prices that exceeded the rate of inflation in 2020. And so I think that may have a very big influence. One of the concerns is that drug manufacturers may just jack up the prices of -- list prices overall from the get-go. So it's a definite balancing act. And to Don's point, there's some -- a lot of moving pardons that we're still kind of following along.

ACTING BOARD MEMBER RUFFINO: And just as a follow-up, and you sort of partially addressed my next question, and I also recognize that it's difficult maybe today, at this stage, but do we have a sense how will this affect our approach to the 2026-2030 pharmacy benefit strategy?

CHIEF CLINICAL DIRECTOR LOGAN: Certainly around

transparency and understanding the prices, the costs, the utilization of drugs and really understanding where profits come from with a future partner is very important. And essentially to have our future partner invested with our strategy, with our strategic plan, and really understand the role of pharmacy benefits, and medical benefits, and integrating that, so we look at the total cost of care rather than just the cost of pharmacy care, because our members obviously don't think of it that way. Their a whole person rather than just their pharmacy and just their medical side.

ACTING BOARD MEMBER RUFFINO: And one last or -- oh.

HEALTH PLAN RESEARCH & ADMINISTRATION CHIEF JARZOMBEK: I just add that we -- also on the -- with our next partner, we want to have shared goals, and so shared approaches and visions for like things like biosimilars first, where we're helping support and change the industries by using those drugs, prescription drugs that are truly going to like help get us away from some of the things that we're experiencing today. And so that's what we're looking for in a new partner as well.

ACTING BOARD MEMBER RUFFINO: And just real quick too, I know you mentioned disruptive entrants and you even -- did we know how -- or do we anticipate how these

changes will impact members' access or -- and prescription cost?

CHIEF CLINICAL DIRECTOR LOGAN: We're hoping -- so we have yet to start that contracting process, but we're hoping that there will be an overall -- a downward pressure on drug prices with increased transparency and affordability measures like biosimilar first and things like that.

ACTING BOARD MEMBER RUFFINO: Again, on behalf of all of our members, thank you for the hard work and for everything that you do. Your advocacy work is exemplary. Thank you.

And with that, I'm done, Mr. Chairman. Thank you, sir.

CHAIR RUBALCAVA: Thank you, Mr. Ruffino.

Jose Luis Pacheco, Trustee

COMMITTEE MEMBER PACHECO: Yes. Thank you, Chairman Rubalcava, and thank you, Dr. Logan, and thank you gentlemen for your -- for your input. So my question is around the PBM, the pharmacy benefit manager legislation. And I just wanted to know the status of those federal bills that were introduced the last two years, that -- I think there were five of them that had bipartisan support, where are they? Did they make it out of committee and so forth? Is there anything suggestion?

CHIEF HEALTH DIRECTOR MOULDS: If I could. I think Danny is going to be speaking a little bit about that on Wednesday --

COMMITTEE MEMBER PACHECO: Okay.

CHIEF HEALTH DIRECTOR MOULDS: -- in his legislative update.

COMMITTEE MEMBER PACHECO: Fantastic then. And then -- so my next question is, I noticed there were some papers that were mentioned on the G -- on the government -- the Government Accounting Office and some of investigations on the PBM. I was just going to ask the Chairman Rubalcava if we could -- if that could be committee direction to have those -- have us read some of that material as well.

CHAIR RUBALCAVA: Can you clarify the request again?

COMMITTEE MEMBER PACHECO: The GAO, the Government Accounting Office.

COMMITTEE MEMBER TAYLOR: You want the -- submitted to our resources.

COMMITTEE MEMBER PACHECO: Yes, resources. Yes, the resources sorry -- into our resources, so we can -- we can further education on what's been going on.

CHAIR RUBALCAVA: Of course.

COMMITTEE MEMBER PACHECO: That would be

wonderful. And then other than that, that is it. That's what I wanted to -- thank you very much.

CHAIR RUBALCAVA: Thank you. Anymore questions from the Committee, comments?

Thank you for the presentation and that concludes the update.

We do have public comment. I'm sorry, let's go to summary of Committee direction.

CHIEF HEALTH DIRECTOR MOULDS: I have one item -- thanks -- which is to upload the FTC papers to the shared resource.

CHAIR RUBALCAVA: Right. And I believe there was -- I'm not sure if it was Committee direction, but there was some discussion I think from Mr. Ruffino about making sure we have a robust member communication on long-term care. I'm sure that's taken care of and regular updates, but I'm sure that's just --

CHIEF HEALTH DIRECTOR MOULDS: Happy to take that as Committee direction as well.

CHAIR RUBALCAVA: Thank you.

COMMITTEE MEMBER TAYLOR: We've got one more question.

CHAIR RUBALCAVA: And we have one more question, Ms. -- Trustee Walker.

COMMITTEE MEMBER WALKER: Ho, Don. Could you

give us an update or what -- or even an overview of the Assured Allied[SIC]. I know that happened before I came on the Board, but I think it's -- I think it's a fantastic program and we should --

CHIEF HEALTH DIRECTOR MOULDS: Sure. Yeah. And I can -- we can probably -- what we can probably -- what we can do I think, I'd like to bring the team at a -- at a future Board meeting --

COMMITTEE MEMBER WALKER: Absolutely.

CHIEF HEALTH DIRECTOR MOULDS: -- to really talk about it, because we had a lot of conversations when this was in the making. It launched in May. As I mentioned, I think in both Investment Committee and here, our -- the interest has exceeded, not only our expectations, but I think anything that Assured Allies has seen out in the world. It's a terrific program that helps members remain in their homes living independently for much longer than they would without those little assists. Some -- a lot of it is retrofitting, a lot of it is problem solving. Some of it can be targeted home care even. So we'll come back with that. And we have -- we have data that we're reviewing with Assured Allies on a -- on a monthly basis. And we can talk more about the benefits of that program and next steps.

COMMITTEE MEMBER WALKER: Oh, absolutely. I

think it's a great program, so I'm really looking forward to it.

CHIEF HEALTH DIRECTOR MOULDS: Yeah. Great. Thank you for that.

CHAIR RUBALCAVA: So we should add that as to Committee direction also

CHIEF HEALTH DIRECTOR MOULDS: Yep, absolutely.

CHAIR RUBALCAVA: Thank you.

CHIEF HEALTH DIRECTOR MOULDS: So the third, yes.

CHAIR RUBALCAVA: Anymore comments or questions from the Committee?

Okay. Now, we'll proceed to -- we've done -- we're completed the summary of Committee direction. We'll go to public comment. We have somebody on the phone.

STAFF SERVICES MANAGER I FORRER: Yes, Mr. Chair. We have Linda Hilburn. Go head, Linda.

CHAIR RUBALCAVA: Ms. Hilburn, please continue -- please proceed.

STAFF SERVICES MANAGER I FORRER: Ms. Hilburn, go ahead.

It shows that she's still on the line.

CHAIR RUBALCAVA: We're ready for your public comment on the phone. Please proceed.

Do we have her on the phone?

STAFF SERVICES MANAGER I FORRER: It shows that's

she's still on the line, but we can ask her to call back.

CHAIR RUBALCAVA: Okay. Thank you.

We'll go next to Mr. Tim Behrens.

TIM BEHRENS: Well, I'm not trying to be a pest here coming down again.

(Laughter).

TIM BEHRENS: Well, I took Don up on his generous offer. Went outside to talk to the stakeholder who is very thankful and will be contacting Don.

And of course, he had another question. They're looking at their different choices and their primary care provider doctor next to her name says subject to change, so I'm wondering what that means, if I'm looking to invest in a new program.

CHIEF HEALTH DIRECTOR MOULDS: Yeah. Sorry. Why don't we -- we'll take a look and I'm not aware of that as a specific designation in myCalPERS or on the website, but we'll work with the member and help them with their options.

TIM BEHRENS: Okay. Thank you very much, I promise that's the last time --

CHAIR RUBALCAVA: No. We appreciate you being a good advocate for other members.

(Laughter).

CHAIR RUBALCAVA: Thank you.

Okay. Do we have the person on the phone? Are they back.

BOARD CLERK ANDERSON: They're working on trying to get her back real quick.

STAFF SERVICES MANAGER I FORRER: Oh, it looks lie she hung up.

CHAIR RUBALCAVA: She's on now?

Okay. Please.

STAFF SERVICES MANAGER I FORRER: No. We have no more callers.

CHAIR RUBALCAVA: Oh, there's -- oh, no more callers. Okay. Thank you. So that concludes public comment.

And I move the -- to move to adjourn the meeting. So thank you, everybody. We'll see everybody in November. And next committee sets up in 10 minutes. 2:15.

Thank you.

(Thereupon California Public Employees' Retirement System, Pension and Health Benefits Committee open session meeting adjourned at 2:02 p.m.)

CERTIFICATE OF REPORTER

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

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

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

IN WITNESS WHEREOF, I have hereunto set my hand this 24th day of September, 2024.

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

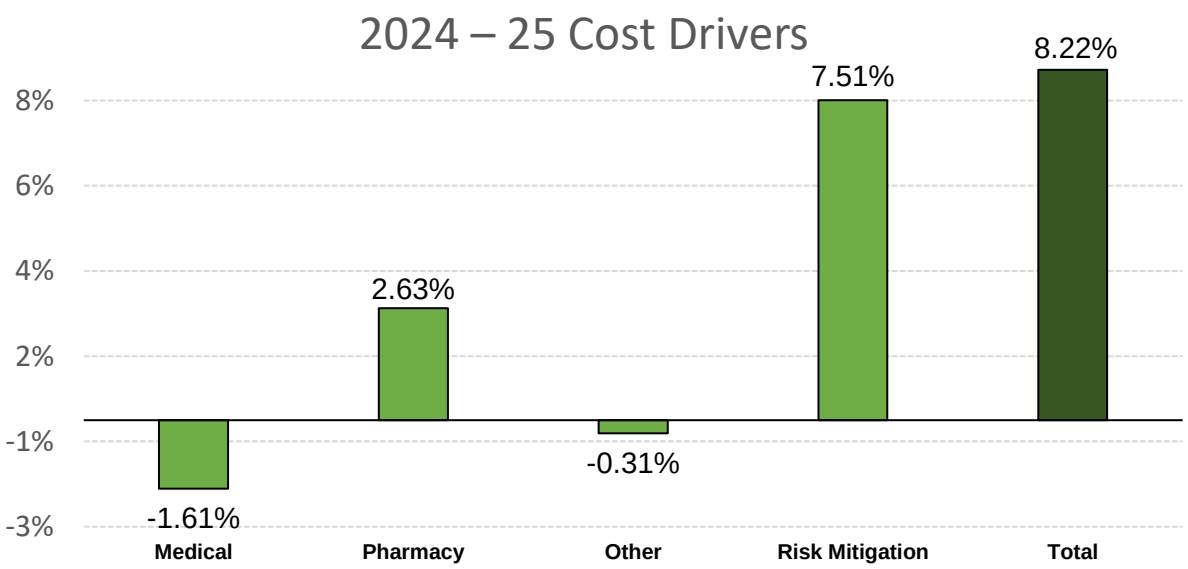
Approval of 2025 HMO and PPO Premiums

Blue Shield Access+ HMO and EPO (Basic)

2024 Premium	2025 Premium Before Risk Mitigation	2025 Adjusted Risk Score	Risk Mitigation Impact	2025 Premium with Full Transition to New Risk Pool	Percent Change from 2024
$892.49	$1,124.64	1.2009	($158.78)	$965.86	8.22%

$232.15 Negotiated Rate Increase

Board Policy Subsidy



2024 Total Covered Lives: 124,322

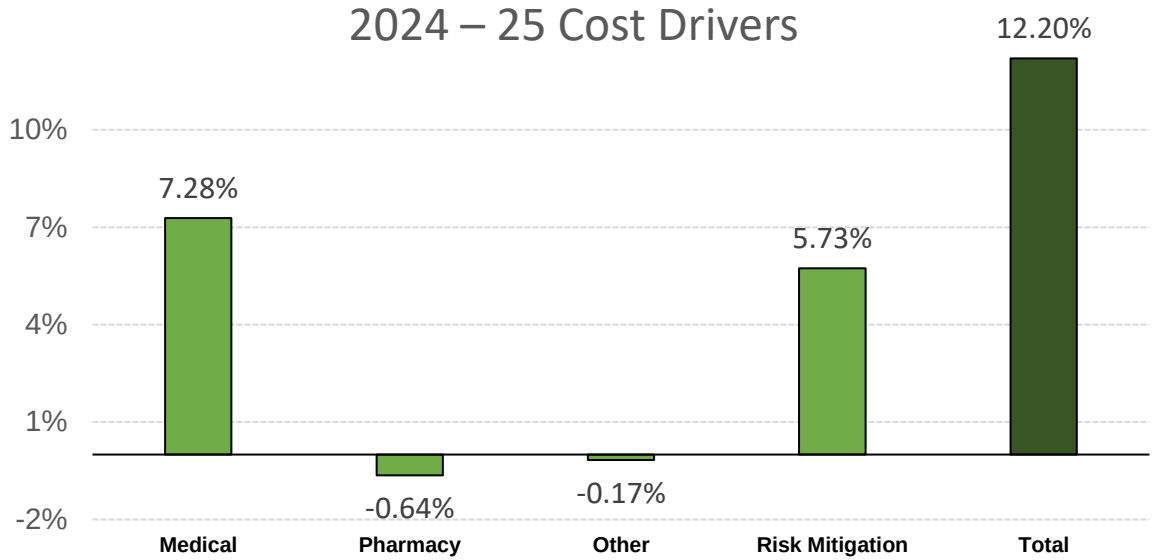
Approval of 2025 HMO and PPO Premiums

Blue Shield Trio HMO (Basic)

2024 Premium	2025 Premium Before Risk Mitigation	2025 Adjusted Risk Scor	Risk Mitigation Impact	2025 Premium with Full Transition to ne Risk Pool	Percent Change from 2024
$810.24	$761.44	0.8485	$147.66	$909.10	12.20%

$48.80 Negotiated Rate Decrease

Board Policy Surcharge



2024 Total Covered Lives: 44,314