HEALTH SERVICE BOARD
CITY & COUNTY OF SAN FRANCISCO

Minutes

Regular Meeting

Thursday, June 11, 2015

1:00 PM

City Hall, Room 416
1 Dr. Carlton B. Goodlett Place
San Francisco, California 94103

- ☐ Call to order
- ☐ Pledge of allegiance
- ☐ Roll call

President Randy Scott
Vice President Wilfredo Lim, excused
Commissioner Karen Breslin
Supervisor Mark Farrell, excused
Commissioner Sharon Ferrigno, arrived 1:26 pm
Commissioner Gregg Sass

This Health Service Board meeting was recorded live by SFGovTV. Links to videotaped meetings and related materials are posted on the myhss.org website.

This meeting was called to order at 1:16 pm. President Scott announced the re-ordering of the agenda to undertake discussion items until a quorum had been attained, noting that the Rates and Benefits section would be deferred until such time.

- ☐ 06112015-02 re-ordered — Discussion item — General public comment on matters within the Board's jurisdiction not appearing on today's agenda

Public comments: None.

- ☐ 06112015-08 re-ordered — Discussion item — President's Report (President Scott)

Documents provided to Board prior to meeting: None.

- President Scott stated that he would be attending an upcoming Trustees and Administrators conference in San Francisco sponsored by the International Foundation of Employee Benefit Plans ("IFEBP"). He will report on the content of the conference at a subsequent Board meeting.
- President Scott and Director Dodd had engaged in a series of email exchanges regarding the current vacancy on the Health Service Board resulting from former Commissioner Shlain's resignation in April. A well-qualified individual has been identified to fill the vacancy, and a recommendation has been made to the Mayor's Office; however, there was insufficient time to vet and interview the candidate prior to this meeting. President Scott has communicated privately with the Mayor's Office requesting that they expeditiously undertake the necessary steps to fill the vacant seat prior to the next meeting to prevent further hampering of the Board's work going forward.
- President Scott formally welcomed Gregg Sass, new commissioner recently appointed to the Health Service Board, attending his first meeting.
- Commissioner Sass thanked President Scott for his welcome, and briefly outlined his background. He retired in 2011 from the City's Department of Public Health as Chief Finance Officer, a position held for 10 years. In 2013, he returned to work as the interim Finance Director for the Health Service System and was involved in the recruitment and hiring of HSS' current CFO, Pamela Levin. During that time, he also worked extensively with Aon Hewitt and Anil Kochhar, as well as many of the Board commissioners, the Board secretary and Director Dodd, whom he has known for approximately 15 years. He stated his hope to bring his experience in healthcare finance combined with his recent HSS experience to the Board.

- President Scott acknowledged and thanked Jean Crossman-Miranda, Senior EAP Counselor, who after 23 years with the City was retiring from the Health Service System. He also stated that he would be a cosigner, along with Director Dodd, on a resolution commending Ms. Miranda's contributions to the City and its employees.

Public comments: None.

06112015-09 re-ordered

Discussion item

Director's Report (Director Dodd)

- Follow-up on UHC self-insured one-time subsidy from the City Plan Stabilization Reserve
- HSS Personnel
- Operations, Data Analytics, Communications, Finance/Vendor Contracts, Wellness/EAP
- Meetings with Key Departments
- Other additional updates

Documents provided to Board prior to meeting:

1. Director's report;
2. Reports from Operations, Data Analytics, Communications, Finance and Contracting, Wellness and Employee Assistance Program.

- Catherine Dodd, HSS Director, stated that she watched the video of the May 14, 2015 Board meeting and intended to ask that the minutes be changed to correct an inaccurate statement made when the applicable agenda item is heard.
- During the last meeting, Commissioner Breslin inquired if the majority of funds in the City Plan stabilization reserve came from retired members and the actuary answered yes. Director Dodd stated that she asked Mr. Kochhar to review his previous answer to Commissioner Breslin's question again for accuracy. Accordingly, she noted that 82% of the funds in City Plan's stabilization reserve in 2013 came from the employers, 4% came from active employees, 10% came from early retirees, and 4% came from Medicare retirees. Similarly, in 2014, 83% of the funds in City Plan's stabilization reserve came from the employers, 4% came from active

employees, 8% came from early retirees, and 5% came from Medicare retirees.

- Director Dodd also made reference to the Data Analytics material in her report, which illustrated the breakdown of the entire HSS membership.
- Commissioner Breslin asked that Mr. Kochhar explain where the surplus City Plan funds came from. She also asked for clarification that the money in the trust fund belongs to HSS members and not the City.
- Mr. Kochhar first confirmed that premiums are deposited into the trust fund. The surplus funds in question were generated because the premiums remitted on behalf of the retirees were excessive. He reiterated that those funds were paid for by the employer, as previously clarified by Director Dodd.
- President Scott stated his understanding that monies deposited into the trust, no matter the source, are under the jurisdiction of the trust unless they are earmarked for a specific purpose. He asked Erik Rapoport, Deputy City Attorney, for clarification on ownership of funds retained in the trust and suggested a future discussion on sources of funds and policy parameters.
- Mr. Rapoport concurred that a future discussion on trust fund money would be appropriate. He stated that the Board has not previously sought to trace specific funds. Charter Section 12.203 states, "The Health Service System fund shall be a trust fund administered by the Health Service Board in accordance with the provisions of this Charter solely for the benefit of active and retired members of the Health Service System and their covered dependents."
- President Scott requested that the discussion take place prior to the next benefits renewal cycle.
- Director Dodd continued her report noting that the second of two Medicare information meetings for retirees took place the day before at the Koret Auditorium in the San Francisco Main Library. The event was extremely well

attended at near capacity. The proposed Blue Shield National PPO was explained and after numerous questions, many members were in favor of adding a national PPO plan. Over 70 questions were asked. The Medicare presentation and Q&As will be posted on the myhss.org website.

- The remainder of the Director's Report may be viewed on the myhss.org website.
- President Scott stated that he attended HSS' first Medicare forum in May. As a result of that meeting, he requested creating separate contact information for the Board, i.e., one email address for the entire Board and a dedicated telephone number that would ring at the secretary's desk. The Board's contact information would be posted on the myhss.org website and in the open enrollment materials.
- Commissioner Ferrigno arrived during this agenda item.

Public comments: Claire Zvanski, RECCSF representative, stated that many retired members expressed concern at being unable to make the Medicare forum at the Koret Auditorium the previous day. Since she attended the first meeting in May, she was able to disseminate information from that forum to various retiree groups and also referred them to the myhss.org website for the videotaped presentation.

Ms. Zvanski also acknowledged Margaret O'Sullivan's (HSS Wellness Plan Coordinator) participation in the retiree meeting the previous day. Ms. O'Sullivan has been participating in the retiree meetings for three or four months and has made an invaluable contribution, which has been enthusiastically received by the retirees.

Dennis Kruger, representative for active and retired firefighters, asked Director Dodd for clarification on the vision services provided by Kaiser and Vision Service Plan ("VSP"), and her statement at the Medicare meeting that "VSP and Kaiser do not mix." He also asked for confirmation that Kaiser's vision services may be submitted to VSP for reimbursement.

Director Dodd stated that all members have vision benefits provided through VSP; however, Kaiser also offers optometry services. There was a question asked at the Medicare forum whether Kaiser members could receive optometry services through Kaiser. She stated that any Kaiser vision services submitted to VSP would not be reimbursed at 100%.

☐ 06112015-01 re-ordered

Action item

Approval (with possible modifications) of the minutes of the meetings set forth below:

- Regular meeting of May 14, 2015

Staff recommendation: Approve minutes.

Documents provided to Board prior to meeting: Draft minutes.

- Commissioner Breslin noted an error on page 6 of the minutes that stated, "Approximately 6,500 retirees in the City Plan have non-Medicare dependents."
- Laini Scott, Board Secretary, said that she would follow up to determine the correct number and revise the May 14, 2015 minutes.
- Commissioner Breslin also stated that the term of Supervisor Farrell's reappointment to the Health Service Board was incorrect. Page 21 of the minutes indicated that Supervisor Farrell was reappointed to a five-year term expiring on May 15, 2020.
- Ms. Scott stated that Supervisor Farrell's revised term on the Health Service Board was taken from a letter written by Board of Supervisors' President, London Breed.
- Director Dodd also requested that the numbers discussed at the beginning of her Director's Report be inserted into the minutes on page 8 to clarify the source of contributions (employers or retirees) into City Plan's stabilization reserve, in response to Commissioner Breslin's previous question to Anil Kochhar, Aon Hewitt actuary.

- President Scott suggested that the corrected information from the Director's Report be inserted into the minutes in brackets in the appropriate section.

Public comments: None.

Action: Motion was moved and seconded by the Board to approve the regular meeting minutes of May 14, 2015, as edited.

Motion passed 4-0.

RATES AND BENEFITS

☐ 06112015-03 Action item

Approve Resolution to Board of Supervisors certifying the 10-County Survey results and 10-County amount for the 2016 plan year (President Scott)

Staff recommendation: Approve Resolution and 10-County Survey results presented at Rates and Benefits Committee meeting on March 12, 2015.

Documents provided to Board prior to meeting: Draft Resolution with 10-County Survey.

- President Scott requested that sometime during the month of July all rate cards for the 2016 plan year approved by the Health Service Board be posted on the myhss.org website and remain until Open Enrollment to allow members access to the information.
- Director Dodd reported that the Resolution to the Board of Supervisors certifying the 10-County Survey amount is presented annually. The 10-County amount is used to develop many of the rates, especially those for retirees.

Public comments: None.

Action: Motion was moved and seconded by the Board to approve the Resolution to the Board of Supervisors certifying the 10-County Survey results and the average 10-County amount of $579.24 for the 2016 plan year.

Motion passed 4-0.

□	06112015-04	Discussion item	Committee of the Whole: Presentation of Blue Shield Medicare National PPO. Discuss options of funding Blue Shield retiree plans and side by side rate cards (Blue Shield of California)

Documents provided to Board prior to meeting: Reports prepared by Blue Shield of California and Aon Hewitt.

- President Scott acknowledged the numerous representatives from Blue Shield in the audience and asked that they stand. He thanked everyone for their attendance at this meeting.
- Paul Brown, Blue Shield Account Management Area Vice President, stated that he would not introduce each Blue Shield representative in attendance but noted that they were present to answer questions in their specialty areas—Medicare, pharmacy operations and claims operations.
- At HSS' request, Blue Shield was asked to present an alternative and more cost effective option to the status quo plan for Medicare-eligible retirees.
- Blue Shield's status quo plan for Medicare-eligible retirees includes two different plans:
    - Shield 65-Plus (Group Medicare Advantage with prescription drug); and
    - Access Plus HMO (Medicare-Coordination of Benefits plan) for members living outside the Medicare Advantage service area.
- Some of the advantages to Blue Shield's status quo Medicare plan include:
    - No member disruption to existing coverage;
    - Retirees retain existing Primary Care Physician and medical group;
    - Care management is delegated to the medical groups;
    - Competitive blended rates for Shield 65-Plus and Access Plus HMO)

- The one disadvantage of the status quo plan is no anticipated expansion of the Shield 65-Plus network (i.e., San Mateo County).
- Blue Shield's alternative option was a national Preferred Provider Organization ("PPO") network coordinated with Medicare Parts A and B, with Medicare as the primary payer. This alternative plan would be a full replacement of the status quo plan and would not be offered in conjunction with the status quo plan.
- The existing Prescription Drug Plan ("EGWP") would remain in place in the alternative national PPO option.
- Since Blue Shield is part of the Blue Shield and Blue Cross association, the proposed new national PPO plan would allow retirees access to all Blue Shield and Blue Cross networks in California and throughout the United States. The national network is in excess of 94% of all providers in the United States.
- In the proposed new national PPO plan, members would continue to have access to the following programs:
    - NurseHelp 24/7, which provides round-the-clock access to registered nurses; and
    - Life Referrals 24/7, which provides expert assistance on personal, financial and legal issues.
- Other advantages to the national PPO plan included:
    - No medical group or primary care physician assignment required;
    - Retirees would be allowed to self-refer to a specialist;
    - Copayments and copayment maximums similar to HSS' current Shield 65-Plus and Access Plus HMO (Medicare Coordinated Plan);

    - Most providers in the Shield 65-Plus (GMAPD) plan are also in the PPO.
- The disadvantages of the national PPO plan include:
    - No clinical or disease management by Blue Shield or the medical groups currently in Blue Shield's status quo plan, which could impact utilization and cost;
    - Silver Sneakers (gym discount program) is not available;
    - Retirees must provide a Medicare ID card as well as a Supplement to Medicare PPO ID card to a provider at point of care, similar to Access-Plus (Medicare Coordination of Benefits plan).
    - Approximately 1.9% of retirees would be impacted by a change to the national PPO plan because their primary care physician is not in Blue Shield's PPO.
- President Scott asked if Blue Shield had a plan in place to seek to contract with providers who are not in its PPO network.
- Mr. Brown stated that Blue Shield has the ability to attempt to recruit physicians who are not in its networks, but there is no guarantee that the provider would join. He noted that Medicare would provide 80% coverage and there is a reimbursement option for out-of-network services.
- See Blue Shield's benefits and coverage attachment for side-by-side comparisons of its status quo plan and the proposed national PPO plan.
- Commissioner Breslin inquired about preventive services not being covered out-of-network.
- Mr. Brown responded that to the degree that those services would be covered by Medicare, there would be some coverage. However, Blue Shield has a policy for all PPO plans that

preventive care with non-participating providers is not covered. This is the same for the status quo plan.

- Commissioner Breslin asked if the Mills Peninsula and Palo Alto Medical Groups were in Blue Shield's national PPO network.
- Mr. Brown confirmed that both medical groups were in Blue Shield's PPO network. He stated that active members and early retirees would not have the same access to their existing doctors when they move into the Medicare Advantage network after turning 65.
- Commissioner Breslin noted that members in those medical groups turning 65 would have their coverage disrupted. She asked how many members would be impacted and whether the PPO plan could accommodate those retirees.
- Mr. Brown stated that the Medicare PPO is one large network that would be able to accommodate the retirees in question.
- Director Dodd stated that while she could not give the exact number, San Mateo County has the second largest population of retirees.
- Commissioner Breslin asked for an explanation why the in-network services under the out-of-pocket maximum in the new PPO plan would be $6,350 and the Access Plus out-of-pocket maximum would be $2,000.
- Kris Perreras, Blue Shield Account Manager, confirmed that currently Blue Shield's Access Plus network's out-of-pocket maximum is $2,000 per individual and $4,000 per family.
- The new PPO plan's out-of-pocket maximum would be $6,350 per individual and $12,700 per family. She stated that the majority of HSS retirees are covered under the GMAPD plan or Shield's 65-Plus Plan (approximately 5,300 out of 7,000 retirees). The annual out-of-pocket maximum for Shield's 65-Plus plan

is $6,700 per individual, higher than the new PPO plan.

- There are no deductibles in the proposed new PPO plan and copays mirror the existing Shield 65-Plus plan.
- President Scott stated that the lack of clinical management or monitoring would be an area of concern if the new PPO plan were adopted. He also suggested that preventive care should be emphasized.
- Paul Brown stated that it is not cost-effective for Blue Shield to include disease management in its PPO plan when Medicare is paying 80% of the bill.
- Commissioner Breslin asked if there would be any transparency in the new PPO plan.
- Director Dodd stated that transparency would be greatly increased in the new PPO plan because HSS would be paying the bills. Also, Sutter would have to accept the amount Medicare pays. It currently receives more than what Medicare pays.
- Commissioner Breslin stated that, similar to her suggestion regarding UnitedHealthcare's national PPO, a Request for Proposal ("RFP") should have been conducted on this proposed PPO plan as a matter of due diligence.
- President Scott stated that the RFP issue had been addressed at the last meeting and would be actively considered in the next renewal cycle.

Public comments: Stephanie Marmane, Vice President of Contracting and Accountable Care with the Brown and Toland Medical Group, stated that currently 3,800 Medicare-eligible retirees are enrolled in Shield's 65-Plus Medicare Advantage HMO Plan. She stated that one important advantage in remaining with the status quo plan, specifically the Shield's 65-Plus option, is the coordinated delivery of care provided through the activities of Brown and Toland Medical Group to ensure that patients receive the right care at the right time. The primary care physician's role is not only to take care

of everyday health and illness but also to help prevent medical errors, duplication of tests, drug interactions and unnecessary hospitalization. When nurses, care coordinators, social workers, medical directors and other staff work together to coordinate a patient's care through a delegated model such as Brown and Toland, patients benefit through faster recovery and those with serious chronic conditions experience improved quality of life. She urged the Health Service Board to consider the member impact of losing coordination of care. She stated that Shield's 65-Plus plan is the only option that would allow Medicare-eligible members to receive coordination of care.

Dennis Kruger, representative for active and retired firefighters, expressed disappointment that Blue Shield's status quo plan does not include the expansion of Medicare Advantage services in San Mateo County, noting that there are quite a few retired members living on the Peninsula. He also stated that including Silver Sneakers in the new PPO plan would be an advantage.

Fiona Wilson, M.D., Chief of Clinical Transformation at Brown and Toland and President of My Health Medical Group, a level 3 patient center medical home in San Francisco, asked the question, "What does the City of San Francisco really want?" She suggested that the City wants a healthy retiree population, to spend less City and taxpayer dollars and attain better outcomes for its retired members. She suggested continuing with the infrastructure and services currently provided to retirees through Brown and Toland. Dr. Wilson urged the Health Service Board to continue to promote Shield's 65-Plus plan because it benefits a wide number of senior patients and is working for patients and providers.

Claire Zvanski, representative for RECCSF, expressed appreciation to the Board for the questions asked. She stated that looking at the proposed PPO plan from a cost perspective appeared to be the way to go. However, she was dismayed to learn that case management and options for additional services, such as preventive care, were not included; especially since it is somehow cost-effective for Kaiser and UHC to include such services in their plans. She stated that perhaps Blue Shield lost its

non-profit status because they were looking at the bottom line. She liked the idea of an expanded network that allowed retirees' access to providers out of basic service areas. She noted that the loss of a benefit such as Silver Sneakers impacts many members. She stated that accepting the proposed national PPO plan may be a little premature and suggested that Blue Shield go back and refigure what was being offered. She expressed concern that perhaps some of the disadvantages outweighed the advantages.

Herbert Weiner, retired City employee, expressed confusion and overwhelm regarding Blue Shield's proposed new PPO plan. He stated that he liked the option of being able to see a doctor in both Brown and Toland and Hills Physicians Medical Groups rather than being restricted to one. He has had experience with primary care physicians and their networks of preferred physicians, which has not always worked out well. He also expressed support for preventive care because it is cost-effective across the board, as well as the annual free medical examinations through Brown and Toland.

Director Dodd inquired if the Board had read the e-mails forwarded by the Board Secretary from retirees who had attended the Medicare educational forum.

President Scott confirmed that the e-mails from the previous seminar in May, as well as the forum the previous day, had been received and read. The two emails recently received expressed support for Blue Shield's proposed new PPO plan. He asked Paul Brown to approach the podium to explain why Silver Sneakers was not included in the PPO plan and whether it would be included in an ensuing year.

Mr. Brown stated that he would need to confer with Blue Shield's product team to provide an answer but that Silver Sneakers is packaged with its Medicare Advantage program and it may be as simple as that.

Charles Lee, Blue Shield Medicare representative, stated that one of the reasons Silver Sneakers was not included in the PPO proposal was timeliness in attempting to be responsive to the needs of the City. Typically, Silver Sneakers is bundled with the

Medicare Advantage product, such as GMAPD Shield's 65-Plus.

President Scott stated his hope that, if the Board approved the proposed PPO plan, Blue Shield would take a second look at the inclusion of a benefit such as Silver Sneakers in the next renewal cycle.

Dennis Kruger asked if the need for two or three member cards (i.e., Blue Shield subscriber card, Medicare card) could be reduced to just one card if the proposed PPO plan was approved.

□ 06112015-05 Action item

Approve Blue Shield fully-insured 65-Plus Group Medicare Advantage Prescription Drug Plan and the Blue Shield Access-Plus Medicare Coordination of Benefits premiums and contributions for the 2016 plan year ***OR*** approve Blue Shield fully-insured National PPO for Medicare retiree premiums and contributions for the 2016 plan year (Aon Hewitt)

Staff recommendation: Approve Blue Shield fully-insured National PPO.

Documents provided to Board prior to meeting: Report prepared by Aon Hewitt.

- President Scott stated that two rates cards would be presented, Blue Shield's fully-insured HMO renewal for Medicare retirees for the 2016 plan year and Blue Shield's proposed national PPO plan for Medicare retirees, the replacement option discussed in the prior agenda item. He noted that only one plan could be adopted by the Board.
- Anil Kochhar, Aon Hewitt actuary, reported that Blue Shield reduced its 2015 65-Plus (MAPD)/Access Plus (COB) monthly rate from $378.56 to $368.42 for the 2016 plan year. See page 4 of Aon Hewitt's report for Blue Shield's status quo monthly rate card.
- The monthly rate for Blue Shield's proposed national PPO plan for 2016 is $365.12. See page 6 of Aon Hewitt's report for Blue Shield's national PPO monthly rate card.

- See page 7 of Aon Hewitt's report for the standard comparison of Blue Shield's 65-Plus/Access Plus versus the national PPO rates and contributions for the 2016 plan year.
- See the Appendix (page 9) of Aon Hewitt's report for comparison of Blue Shield's 2015 65-Plus/Access Plus retiree program and the Medicare National PPO for 2016.
- Aon Hewitt made no recommendation for either plan. Mr. Kochhar stated that the rates for the status quo plan are slightly higher than the national PPO plan. He noted that the status quo rates were reduced through final negotiations.
- Commissioner Breslin stated that her interest in the new PPO plan was the broader network, which would benefit some members. However, since retired members would have the option of enrolling in UHC's national PPO plan, she did not find a compelling reason to vote in favor of this plan due to the issues raised.
- Commissioner Sass stated that the UHC option was an easier decision to make since the national PPO plan was offered alongside City Plan. In the case of Blue Shield, the choice was either/or. Blue Shield's status quo plan offered case management and coordination of care. The national PPO plan did not offer case management but allowed members to see a physician anywhere in the United States. The cost of both plans were so similar that the rate would likely not be a determining factor. The Board should consider the needs of the retirees. Some retired members are in good health and active while others are not active and have chronic needs requiring the coordination of care.

Public comments: None.

Action #1: Motion was moved and seconded by the Board to approve Blue Shield's fully-insured 65-Plus Group Medicare Advantage Prescription Drug Plan and the Blue Shield Access Plus Medicare Coordination of Benefits premiums and contributions for the 2016 plan year.

Motion failed 2-2.

Commissioners Breslin and Ferrigno voted in favor of the motion.

Commissioners Scott and Sass voted against the motion.

Action #2: Motion was moved and seconded by the Board to adopt Blue Shield's National PPO plan for the 2016 plan year.

Motion failed 2-2.

Commissioners Scott and Sass voted in favor of the motion.

Commissioners Breslin and Ferrigno voted against the motion.

President Scott asked Erik Rapoport, Deputy City Attorney, for the next course of action.

Mr. Rapoport stated that occurrences such as this is the reason seven Board members are needed to vote on important matters. He stated that a unanimous vote was needed to pass either plan. Unless two members were willing to change their vote, this item would not pass and another meeting would need to be scheduled with the goal of reaching consensus. The process for approving the rates is in the Charter and must be completed in enough time to be approved by the Board of Supervisors for the commencement of Open Enrollment.

Director Dodd stated that at one point, she was told by Blue Shield that Medicare provided case management to retired members, not Blue Shield. She asked that Kris Perreras, Blue Shield representative, to clarify. She also asked Ms. Perreras to describe the second opinion process.

Ms. Perreras stated that in the MAPD plan, case management is provided by the medical group. Under the HMO COB plan, Medicare is primary and as such, is the case manager.

Ms. Perreras stated that under the HMO plan, second opinions are covered within the HMO network, noting that this is a special process created for CCSF. The process is not automatic and requires notice to Blue Shield to ensure that correct payment is made since the general standard is that second opinions are covered within the same medical group.

Unlike the HMO plan, Blue Shield's national PPO plan would allow members to seek a second opinion within the vast network of doctors in or outside California.

□	Meeting Break		Recess from 3:08 to 3:24 pm
□	06112015-05 (Continued)	Action item	At President Scott's request, the following motion was made.

Action: Motion was moved and seconded by the Board to reconsider the prior item: approval of Blue Shield's fully-insured 65-Plus Group Medicare Advantage Prescription Drug Plan and Blue Shield's Access Plus Medicare Coordination of Benefits premiums and contributions for the 2016 plan year ***OR*** approve Blue Shield's fully-insured National PPO for Medicare retiree premiums and contributions for the 2016 plan year.

Motion passed 4-0.

Public comments: Dennis Kruger, representative for active and retired firefighters, stated that at first glance, he liked Blue Shield's national PPO plan. The comparison chart indicated that both plans are identical; however, they are not since the national PPO plan does not include Silver Sneakers. He asked that the Board remain with the current plan and consider the PPO plan next year, even though there will be no additional coverage provided in San Mateo. He suggested that Blue Shield return next year with a national plan that requires just one card, includes Silver Sneakers and has copays either identical or close to UnitedHealthcare's.

Claire Zvanski, RECCSF representative, also suggested that the Board reconsider this item stating that more information was needed about the network and network displacement. She asked about the number of Hetch Hetchy members who would be impacted by the change in options. She also stated that not all of the information presented was clear, such as where MAPD ends and the national network begins and how members outside the area of need would be impacted, as well as physician displacement.

Commissioner Sass stated his intent to change his prior vote and approve Blue Shield's status quo plan. He stated that members who favored the national PPO plan would still have that option available through UnitedHealthcare. Members requiring primary care support in determining their larger healthcare needs would continue to have the benefits of Shield's 65-Plus plan.

Action: Motion was moved and seconded by the Board to approve Blue Shield's fully-insured 65-Plus Group Medicare Advantage Prescription Drug Plan and Blue Shield's Access Plus Medicare Coordination of Benefits premiums and contributions for the 2016 plan year.

Motion passed 4-0.

□ 06112015-06 Action item

Approve UnitedHealthcare ("UHC") Medicare Advantage Prescription Drug Plan ("MAPD") National PPO fully-insured premiums and contributions for 2016 plan year (Aon Hewitt)

Staff recommendation: Approve MAPD National PPO premiums and contributions.

Documents provided to Board prior to meeting: Report prepared by Aon Hewitt.

- President Scott reminded everyone that the Board previously voted to offer this option for 2016, so no discussion of this plan would ensue. The purpose of this agenda item was to review and approve the rate card for UHC's fully-insured Medicare Advantage Prescription Drug ("MAPD") National PPO for retirees for the 2016 plan year.

- Anil Kochhar reported that the monthly premium for UHC's MAPD National PPO is $305.12, slightly higher than the existing City Plan. He noted that City Plan was afforded a high stabilization credit, which otherwise would have made it slightly higher than the National PPO.
- Aon Hewitt recommended Board approval of UHC's MAPD National PPO rate card for plan year 2016 as presented.

Public comments: None.

Action: Motion was moved and seconded by the Board to approve UnitedHealthcare's MAPD National PPO premiums and contributions for the 2016 plan year.

Motion passed 4-0.

□ 06112015-07 Action item

Approve Kaiser Permanente Senior Advantage fully-insured premiums and contributions for 2016 plan year (Aon Hewitt)

Staff recommendation: Approve Kaiser Permanente Senior Advantage fully-insured premiums and contributions.

Documents provided to Board prior to meeting: Report prepared by Aon Hewitt, "Kaiser Permanente Senior Advantage HMO Plan Renewal for Medicare Retirees."

- Anil Kochhar reported that it is CMS' practice to provide the number for the Medicare Advantage program computation at a later time than is requested by HSS. Depending upon the final number, Kaiser Permanente's Senior Advantage plan will receive either a credit or an offset the following year.
- The final CMS rate for Kaiser Permanente's Medicare enrollees last year generated a credit of $7.75 per member per month ("PMPM") for the proposed 2016 Medicare rates. The early premium estimate for the 2016 plan year is $322.66, which was reduced to $314.91 after applying the $7.75 PMPM credit.

- See rate card on page 4 of Aon Hewitt's report.

Public comments: None.

Action: Motion was moved and seconded by the Board to approve Kaiser Permanente's Senior Advantage fully-insured premiums and contributions for the 2016 plan year, as presented.

Motion passed 4-0.

President Scott noted the conclusion of the 2016 rates and benefits process with the passage of this last agenda item. He thanked HSS staff for their outstanding work and diligence throughout the process, which saved the City millions of dollars, led by indomitable Executive Director, Catherine Dodd. He also thanked the provider partners for being very responsive to the many tough questions asked and bringing the Board's attention to new information and ideas.

President Scott also commended Anil Kochhar, Aon Hewitt actuary, stating that he and the Aon Hewitt team have been superb in working with the Board throughout the year.

At President Scott's request, the rate cards passed during this rates and benefits renewal cycle will be posted on the myhss.org website and remain until Open Enrollment as a reference to the Board's decisions and actions.

REGULAR MEETING MATTERS

□ 06112015-10 Discussion item **HSS Financial Reporting as of April 30, 2015** (Pamela Levin)

Documents provided to Board prior to meeting:

1. Financial update memo;
2. Report for the Trust Fund;
3. Report for the General Fund Administration Budget.

- Pamela Levin, HSS Chief Financial Officer, provided a brief summary of revenues and expenses of the HSS Trust Fund and General

Fund Administrative budget through April 30, 2015.

- The Trust Fund balance is still projected at $83M, which is $9.8M lower than the June 30, 2014 amount.
- Due to delays in hiring, the General Fund Administrative Budget balance is projected to be nearly $900,000 by the end of the fiscal year.
- See financial update memorandum, dated June 11, 2015.
- Commissioner Breslin inquired about the amount in the transfer of forfeitures to the General Fund under Savings & Investments (item (e) on page 3).
- Ms. Levin stated that HSS used prior years' forfeitures from health and dependent care flexible spending accounts to balance the General Fund budget; however, those funds have been substantially reduced due to the $500 rollover allowance and are expected to eventually dry up.

Public comments: None.

□ 06112015-11 Action item

Election of Health Service Board Officers (President and Vice President) for fiscal year 2015-2016
(President Scott)

Documents provided to Board prior to meeting: None.

- At President Scott's request, Commissioner Breslin presided over this agenda item.

Public comments: None.

Action: Motion was moved and seconded by the Board to nominate Commissioner Randy Scott as President and Commissioner Wilfredo Lim as Vice President of the Health Service Board for fiscal year 2015-16.

Motion passed 4-0.

□	06112015-12	Action item	Approve Health Service System Membership Rules updates (Mitchell Griggs)

Staff Recommendation: Approve updates.

Documents provided to Board prior to meeting: Summary of proposed changes and draft HSS Membership Rules.

- Mitchell Griggs, HSS Chief Operating Officer, reviewed proposed policy changes for the HSS membership rules to be effective January 1, 2016.
- Two policy changes corrected the effective dates of the dependent and healthcare flexible spending accounts.
- The benefits coverage period was updated to reflect the bi-weekly pay periods for the 2016 plan year.

Public comments: None.

Action: Motion was moved and seconded by the Board to approve the updates to the Health Service System membership rules for the 2016 plan year.

Motion passed 4-0.

□	06112015-13	Action item	Vote on whether to cancel July 2015 Health Service Board meeting (Director Dodd)

Documents provided to Board prior to meeting: None.

- Director Dodd reported that it has been a tradition of the Health Service Board to recess in July of each year and cancel its regular meeting.

Public comments: None.

Action: Motion was moved and seconded by the Board to cancel its regular meeting on July 9, 2015.

Motion passed 4-0.

□	06112015-14	Discussion item	Report on network and health plan issues (if any) (Respective plan representatives)

Public comments: None.

□	06112015-15	Discussion item	Opportunity to place items on future agendas Public comments: None.
□	06112015-16	Discussion item	Opportunity for the public to comment on any matters within the Board's jurisdiction Public comments: Herbert Weiner, retired City employee, commended Jean Crossman-Miranda (retiring Senior EAP Counselor) for instituting the workshops on bullying in the workplace. He expressed the hope that the workshops will continue to be offered to City employees. Claire Zvanski, former Health Service Board member, concurred with Mr. Weiner's comments regarding Jean Crossman-Miranda's contributions as Senior EAP Counselor, stating that Ms. Miranda has been a dedicated counselor and City employee over the years and was one of the more exceptional people in the EAP world. Ms. Zvanski also asked if HSS needed Board members and the constituency to attend the budget hearings to offer support. Director Dodd thanked Ms. Zvanski and stated that if an agreement could not be reached on HSS' budget at the upcoming BOS Budget Committee meeting, a request would be sent to the Health Service Board and members to communicate directly with members of the Budget Committee. The budget hearing was scheduled on June 15, 2015 at 10:00 am in the Board of Supervisors' Chamber.
□	Adjourn: 3:55 pm		

Summary of Health Service Board Rules Regarding Public Comment

- Speakers are urged to fill out a speaker card in advance, but may remain anonymous if so desired.
- A member of the public has up to three (3) minutes to make pertinent public comments before action is taken on any agenda item.
- A member may comment on any matter within the Board's jurisdiction as designated on the agenda.

Health Service Board and Health Service System Web Site: http://www.myhss.org

Disability Access

Regular Health Service Board meetings are held at City Hall, 1 Dr. Carlton B. Goodlett Place, in Hearing Room 416 at 1:00 PM on the second Thursday of each month. The closest accessible BART Station is Civic Center, three blocks from City Hall. Accessible MUNI lines serving this location are: #42 Downtown Loop, and the #71 Haight/Noriega and the F Line to Market and Van Ness and the Metro stations at Van Ness and Market and at Civic Center. For more information about MUNI accessible services, call (415) 923-6142. There is accessible parking in the vicinity of City Hall at Civic Center Plaza adjacent to Davies Hall and the War Memorial Complex.

Accessible seating for persons with disabilities (including those using wheelchairs) will be available.

In order to assist the City's effort to accommodate persons with severe allergies, environmental illnesses, multiple chemical sensitivity or related disabilities, attendees at public meetings are reminded that other attendees may be sensitive to various chemical-based products. Please help the City accommodate these individuals.

Knowing Your Rights Under the Sunshine Ordinance

Government's duty is to serve the public, reaching its decision in full view of the public. Commissions, boards, councils and other agencies of the City and County of San Francisco exist to conduct the people's business. This ordinance assures that deliberations are conducted before the people and that City operations are open to the people's review. For more information on your rights under the Sunshine Ordinance or to report a violation of the ordinance, visit the Sunshine Ordinance Task Force website at http://www.sfgov.org/sunshine.

Lobbyist Registration and Reporting Requirements

Individuals and entities influencing or attempting to influence local legislative or administrative action may be required by the San Francisco Lobbyist Ordinance [SF Campaign & Governmental Conduct Code § 2.100] to register and report lobbying activity. For more information about the Lobbyist Ordinance, please contact the San Francisco Ethics Commission at 25 Van Ness Avenue, Suite 220, San Francisco, CA 94102; telephone (415) 252-3100; fax (415) 252-3112; web site www.sfgov.org/ethics.

Summary of Health Service Board Rules Regarding Cell Phones and Pagers

- The ringing and use of cell phones, pagers and similar sound-producing electronic devices are prohibited at Health Service Board and committee meetings.
- The Chair of the meeting may order the removal of any person(s) in violation of this rule from the meeting room.
- The Chair of the meeting may allow an expelled person to return to the meeting following an agreement to comply with this rule.

The complete rules are set forth in Chapter 67A of the San Francisco Administrative Code.

If any materials related to an item on this agenda have been distributed to the Health Service Board after distribution of the agenda packet, those materials are available for public inspection at the Health Service System during normal office hours. For more information, please contact Laini K. Scott at (415) 554-1722 or email at laini.scott@sfgov.org.