HEALTH SERVICE BOARD
CITY & COUNTY OF SAN FRANCISCO

Minutes

Special Meeting
Board Forum

Thursday, November 12, 2015

1:00 PM

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

- ☐ Call to order

- ☐ Roll call

President Randy Scott
Vice President Wilfredo Lim
Commissioner Karen Breslin
Supervisor Mark Farrell, excused
Commissioner Sharon Ferrigno, excused
Commissioner Stephen Follansbee, M.D.
Commissioner Gregg Sass, excused

This special 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 1:03 pm.

President Scott stated that the purpose of this special meeting was to pause for a moment to look at the Board's accountabilities as well as a range of issues. Over a year ago, he requested that the City Attorney provide information on the fiduciary roles of Health Service Board members. Some core fiduciary requirements are unique to the Health Service Board in its role of administering the Trust Fund for CCSF Health Service System members.

□ 11122015-01 Discussion item **Fiduciary Standards and Board Member Roles**
(Erik Rapoport, Deputy City Attorney)

- Board role in adopting plans for HSS members
- Board role in investing HSS Trust Fund assets - Application of prudent investor/person standard and the need to adopt an HSS investment policy
- Board role in setting HSS policy
- Board role in hearing HSS member appeals

Documents provided to Board prior to meeting:
City Attorney presentation.

- Erik Rapoport, Deputy City Attorney, reported that this presentation was not intended to be an exhaustive list but rather a selection of four basic roles to illustrate the broad range of decisions that commissioners make from time to time.
- Also, this presentation was not intended to provide a comprehensive fiduciary review of the Health Service Board's investment obligations. The intent was to answer two basic questions:
    - What is the fiduciary standard that applies to the Health Service Board's oversight of trust fund assets?
    - Is it appropriate for the Health Service Board to continue to leave trust fund assets invested with the San Francisco Treasurer's Office?
- Mr. Rapoport reviewed the San Francisco Charter language establishing the Health Service System as a trust and providing authorization to invest trust assets:
- Charter Section 12.203 – Establishes the Health Service System as a Trust Fund and identifies beneficiaries (active and retired members of the Health Service System and their covered dependents). The primary purpose of the HSS Trust Fund is to negotiate and approve rates and benefits each year and

to ensure that payment of health insurance premiums are consistent with the Charter based on the employee and employer contribution.

- Charter Section A8.429 – Confirms the Health Service Board and the Health Service System's authority to invest trust fund assets.
- Charter Section A8.423 – Confirms the Health Service Board's investment authority and that administrative expenses related to fund investments may be paid from trust fund assets. Allowed expenses include actuarial expenditures, member wellness programs and communication costs.
- Health Service Board Terms of Reference (approved April 9, 2015) – With the adoption of robust reserve policies, combined with moving to flex-funding in the Blue Shield plan, HSS reserves grew in excess of $70M. The Board inquired into its fiduciary obligations regarding the trust fund assets. In April 2015, the Board adopted an investment administration policy at the recommendation of outside consultant, Tom Iannucci. This policy requires the Board's adoption of a written investment policy statement.
- In addition, the Treasurer's Office made a presentation to the Board in September 2015 regarding the Treasurer's investment policy and the investment of HSS trust fund assets through that office. To date, the Board has adopted the Treasurer's investment policy by default.
- Fiduciary Standards: California Constitutional Standard for Pension Systems – This standard does not apply to the Health Service Board because it relates to the duties of public pension systems.
- Fiduciary Standards: California Uniform Prudent Investor Act ("UPIA") Standard – This standard applies in probate or the fiduciary obligations for a trustee managing an estate. It requires the fiduciary to manage trust assets as a prudent investor by considering

the purpose, terms, distribution requirements and other circumstances of the trust.

- Fiduciary Standards: Employee Retirement Income Security Act of 1974 ("ERISA") Standard – This standard requires the fiduciary to act solely in the interest of the participants and beneficiaries of the plan "with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of like charter and with like aims."
- Fiduciary Standards – San Francisco Retiree Health Care Trust Fund – Board Terms of Reference (Paragraph 3) – the Retiree Health Care Trust Fund is designed to pre-fund the City's obligations to pay for retiree healthcare. It was adopted in 2008 and requires employees hired after January 10, 2009 to contribute 2% of pretax compensation into the fund. It was amended in 2011 to require employees hired before January 2009 to make contributions beginning in 2016.
- Application of Fiduciary Standards to Health Service Board re Investments (retention of third party consultant or investment advisor) – "Fiduciaries acting in accordance with the UPIA/ ERISA prudence standards generally find it appropriate to retain outside expertise when the fiduciaries do not have the expertise necessary to address questions arising in the context of managing or investing plan assets. It is very common for plan sponsors and other fiduciaries to retain third party consultants or investment advisors to advise them on developing an investment policy or recommending an investment program for an employee benefit plan. The expert could advise on whether it is common for similar types of programs to be retained in liquid assets or to be invested in a longer term investment strategy."

- Charter Section A8.422: Adoption of Plans for Members –"The Board shall have power and it shall be its duty by a majority vote of the entire membership of the Health Service Board to adopt a plan or plans for rendering medical care to members of the system or for the indemnification of the cost of said care or for obtaining and carrying insurance against each such costs for such care." This is the primary role of the Health Service Board. The plans shall not become effective until approved by ordinance of the Board of Supervisors, adopted by three-fourths of its members.
- Charter Section 4.102 – Boards and Commissions: Powers and Duties. The Health Service Board makes higher level policy decisions while the Health Service System's day-to-day operations are the responsibility of the department head. The Board's powers include formulating, evaluating and approving goals, objectives, plans and programs and setting policies consistent with overall City objectives. This Charter Section requires Boards to go solely through the department head when dealing with administrative matters.
- Charter Section 16.114: Powers of Inquiry and Review – The Board may require periodic or special reports of departmental costs, operations and expenditures, examine the books, papers, records and accounts of and inquire into matters affecting the conduct of the department or office of the City and County, and may hold hearings, subpoena witnesses, administer oaths and compel the production of books, papers, testimony and other evidence.
- Charter Section 12.200(5) – Health Service Board – The Board shall "receive, consider and, within 60 days after receipt, act upon any matter pertaining to the policies of, or appeals from, the Health Service System submitted to in writing by any member or person who has contracted to render medical

care to members." In the appeal process, Board members act as administrative law judges. When a claim is filed with the Board, it must ensure that the dispute is resolved on a level playing field, which means that there should be no ex parte communications between Health Service Board members and the Health Service System member regarding the member's claim.

- As general counsel to the Health Service System, the City Attorney cannot represent HSS and the Board simultaneously in a member appeal. The City Attorney's Office has established an ethical screen whereby the Board is represented by the City Attorney's Office during member appeals. If the Health Service System requires legal advice, another attorney from the City Attorney's Office will be assigned to represent HSS' interests.
- Communications regarding member appeals should be made through the Board Secretary, who, once the appeal is filed, acts in the capacity of a court clerk for the appeal process. The member and HSS should be copied on all communications.
- If a commissioner is contacted by a HSS member regarding a specific claims-related experience, it is acceptable to provide general information to the member (from the website, member guides and Membership rules) but also the member should be directed to contact HSS Member Services. It would also be acceptable to refer to the head of Member Services or the Director of HSS.
- There is a concern that if a HSS member contacts a commissioner for assistance and the issue is not resolved with HSS resulting in a member appeal, the commissioner would need to recuse himself or herself from hearing the matter.
- Commissioner Breslin stated that the Board now has a direct email address and telephone number. She noted that in some situations, people might email complaints

about the Director and asked how those emails should be handled. Members should be allowed to contact the Board without restriction. She suggested establishing a policy to respond to member emails sent directly to the Board and that the Board President would probably be the person to respond. She did not think it was proper to ignore member correspondence, especially if the complaint was regarding the person the email would be referred to.

- Mr. Rapoport stated that there are two types of emails received by the Board--general complaints about HSS administration or specific complaints regarding member claims. He cautioned that while each member has a First Amendment right to email the Board on any topic, there should be a procedure in place for the Board and HSS to respond to member emails that balances all interests.
- Mr. Rapoport stated that if the Board has issues with the administration of HSS, those concerns will need to be resolved with the HSS Director (per Charter Section 4.102). If a member is unhappy with HSS senior staff or the Director, the Board must communicate with the Director to settle the issue.
- If there were a series of complaints and the Board determined there was a systematic problem, a formal level of inquiry could be invoked through the Powers of Inquiry and Review process. Documents could be obtained and testimony could be heard by the Board.
- President Scott stated that by the creation of an email address and dedicated telephone number, HSS members have been invited to share their concerns with the Board. Thought needs to be given on how these Board communications are processed.
- Mr. Rapoport suggested that the Board give thought to how member emails are handled, perhaps creating a form response. He

cautioned against Brown Act issues in replying back to all in Board emails.

- Commissioner Breslin asked who is considered a fiduciary and whether there have been any recent Supreme Court decisions that redefine the role of a fiduciary.
- Mr. Rapoport stated that while his presentation was not intended to be a comprehensive fiduciary review, it is fair to say that the Health Service Board commissioners are fiduciaries.
- One of the reasons the discussion on fiduciary responsibility occurred was to look at whether it is appropriate to leave HSS trust fund assets with the Treasurer's Office. The Board should create a sensible fiduciary and trust policy around the appropriate use of trust fund assets.
- The City Attorney's Office recommended obtaining expert advice. If, after consulting with an expert, the Board decides to keep trust fund assets with the Treasurer's Office, the Treasurer's investment policy could be adopted as Board policy. The fiduciary review would be based on that decision. By default, HSS is investing funds with the Treasurer's Office, which has a policy.

Public Comments: None.

□	Meeting Break		Recess from 2:05 – 2:10 pm.
□	11122015-02	Discussion item	External Environmental Assessment (near term 12 months, longer term 24 months) (President Scott)

Documents provided to Board prior to meeting: Handouts prepared by Aon Hewitt and HSS.

- Trends (Aon Hewitt)
  - Public and private sectors
  - Insurers/provider consolidation nationally, California, Bay Area
- Won Andersen, Aon Hewitt, reported on trends in the healthcare industry relating to benefits in the next 12 to 24 months.

- Four key factors are occurring in the marketplace today:
    - Looming Excise Tax – approximately two-thirds of plan sponsors (public and private sector) expect to hit the excise tax in 2018.
    - Venture capital and investment in health technology will impact not only health insurers but also how employers deliver benefits and consumers' use of healthcare.
    - Changing workforce – in 2020 there will be five different generations in the workforce across the board. Employers are beginning to consider how to deliver benefits to employees while considering changing workforce factors.
    - Access to public exchanges – currently, public and private sector employers are committed to delivering benefits as part of their core offerings to employees. Mass exodus is not anticipated at this time.
- Government employers and plan sponsors were asked to identify the five most significant challenges they faced with their benefit programs. Employee engagement and motivation in providing tools for employees to understand how to use their healthcare ranked highest at 83%. See page 5 of report, "Summary of Trends."
- Commissioner Follansbee asked if there were regional differences to the number one challenge.
- Ms. Andersen stated that the responses were very similar across the board regardless of geography, industry and size.
- Private employers have been tweaking plan designs and cost sharing strategies over the course of the last five to 10 years and are running out of room to make changes to manage costs.

- Public sector plan sponsors tend to provide very generous cost subsidies, allowing room to address the cost issue.
- Public sector employers are considering key changes to copays and deductibles.
- The private sector employers have begun to treat the adult dependent category differently, such as reduced subsidy for spousal coverage.
- The private sector has also seen dramatic change in high deductible health plans (i.e., $1,500).
- Commissioner Breslin asked if the ACOs have been around long enough to see whether they are performing well. She read in California Health Line that one of the original ACOs had pulled out.
- Ms. Andersen stated that the data on the ACOs is relatively new and not much information is currently available. It is going in the right direction in terms of potential cost savings related to clinical outcomes and quality of care but it is too soon to say definitively.
- Dr. Paige Sipes-Metzler, Aon Hewitt, reported that the success of the ACOs in the Bay area is still being evaluated. While the ACOs have had some effect on certain parts of utilization, costs have not been significantly impacted.
- Director Dodd stated that Blue Shield performed an analysis of HSS' ACO utilization and cost to non-ACO members and in that small analysis, the ACOs were making a difference. The key to the ACOs' success is the hospital commitment.
- See Aon Hewitt's report, "Summary of Trends."

- Issues (HSS)
- State: Taxes, transparency
- Director Dodd reported that Pamela Levin, HSS CFO, compiled a list of federal taxes related to the Affordable Care Act.
- The Patient-Centered Outcomes Research Trust Fund (PICORI) fee has increased this year from $2.08 per covered life to $2.17.
- The transitional reinsurance fee will decrease in 2016, however, that amount is still substantial--$4M.
- The managed care tax ("MCO") reported on at the previous meeting, essentially a tax on a tax to cover the State's Medi-Cal shortfall, has been tossed out for this year. There must be a conclusion by April 2016.
- There has been action by the hospitals and unions to extend Prop 30, which passed several years ago, through a ballot initiative. The intent is to make it permanent, which will charge tax on individuals making more than $230,000 per year. It is unclear whether the tax problem will be solved if it passes.
- Transparency – All Payer Claims Database ("APCD")
- Marina Coleridge, HSS Data Analytics Manager, provided an update on the department's transparency initiatives.
- In a continuing effort to preserve and improve sustainable and quality benefits, the All Payer Claims Database ("APCD") was established to assess the value of care received and access price and quality information.
- The implementation phase of the APCD has recently been completed and it is up and running as a production system.
- On October 1, 2015, Supervisor Farrell chaired a transparency meeting at which Health Service Board Commissioners Scott, Lim and Breslin attended, as well as HSS Director, Catherine Dodd, and several HSS

staff members. Aon Hewitt and members from Catalyst for Payment Reform were also in attendance.

- The transparency meeting included a review of national legislative initiatives as well as specific issues HSS faces in the Northern California market. There are approximately 15-20 states with all payer claims databases.
- A discussion was also held on how HSS could leverage its APCD.
- In general, there was no new information gained at the meeting.
- Ms. Coleridge also attended the Center for Healthcare Transparency forum on October 7, 2015 in San Francisco. The focus of the meeting was to identify regional and statewide entities to partner with to ensure meaningful and actual information on the relative cost and quality of healthcare services provided to 50% of the United States by 2020.
- HSS is continuing to evaluate ways to integrate its APCD and make it more actionable in driving some of its goals.
- In 2013, HSS considered integrating with the California Healthcare Performance Information system administered by the Pacific Business Group on Health ("PBGH"). However, due to difficulty in satisfying the Business Associate Agreement requirements with the City Attorney and another party, HSS did not move forward. Now that the APCD is up and running, Ms. Coleridge will contact the City Attorney's Office to reexamine the previous impediments and see if there is an opportunity to move forward.
- President Scott stated that a graphic on the Health Service System environment had been presented at the October 1, 2015 transparency meeting. He asked that a copy of that graphic be attached with Ms. Coleridge's remarks to show the level of

complexity around trying to determine where transparency begins.

- Bay Area: Nine- County Bay Area Analysis
- Marie Murphy, PhD., HSS Research Assistant, presented an analysis of the nine Bay Area counties to complement the 10-County Survey. The intention was to obtain information on the benefits provided to employees in the neighboring Bay Area counties.
- The counties in order of most to least populous in this analysis were: Santa Clara, Alameda, Contra Costa, San Francisco, San Mateo, Sonoma, Solano, Marin and Napa.
- Information was collected on each county's benefit plans, including premiums for employees-only, employees plus one, employees plus two, plan design, coverage, etc.
- Premiums for retirees with and without Medicare, as well as retirees plus one with and without Medicare, were also reviewed.
- Data on dental plans, vision plans, voluntary benefits, hospitals and whether counties provide coverage for adult disabled children were included in the analysis.
- The average monthly medical premium costs for employees-only by county were included as well as the average employer and employee premium contributions. The averages were not adjusted for many factors which could be considered important such as plan design and number of covered lives per plan. Therefore, the numbers presented should be taken with a grain of salt. An actuarial report may yield other information to be considered.
- The average employee-only premium costs by county are as follows in descending order. Alameda (highest average employee-only premium), Contra Costa, Santa Clara, Napa, Solano, Marin, San Mateo, San Francisco, Sonoma.

- Retrieving data on retirees was particularly difficult due to inaccessibility to some of the administrators of those benefits. Every county had a different means of administering retiree health benefits.
- President Scott asked if the data was going to be refined to determine a summary of major themes in the graphics shown on the charts.
- Director Dodd responded that the goal of this analysis was to see how San Francisco compared to other Bay Area counties and whether there were any similarities.
- Commissioner Breslin asked if the goal of this analysis was to change the 10-County Survey.
- Director Dodd stated that the goal was to see how different the Bay Area analysis was from the 10-County Survey.
- Dr. Murphy reported that the nine Bay Area counties currently offer a total of 67 plans of which she was able to obtain plan design information for 53.
- Detailed information on this analysis may be viewed on the myhss.org website.

Public comments: None.

□ 11122015-03 Discussion item Emerging and Strategic Topics (President Scott)

Documents provided to Board prior to meeting: Handouts prepared by Aon Hewitt, HSS, and Consumer Reports.

- **Pharmacy benefits – tiers equality** (Aon Hewitt)
- Dr. Paige Sipes-Metzler provided an update on pharmacy tiering.
- The pharmacy trend is increasing. Approximately 25% of costs relate to specialty drugs. Special costs are increasing at approximately 20% per year and sustainability is becoming an issue.
- Tiering plan design is a strategy that attempts to balance member costs with access to medication.

- The focus of this presentation was on the two largest HSS health plans, Blue Shield and Kaiser Permanente.
- Under the current pharmacy cost share for non-mail orders, Blue Shield of California has four different costs that are applied to its pharmaceuticals depending upon the formulary. Specialty drugs are in tier 4. Blue Shield is considering a fifth tier for 2018, which would be available for all groups.
- City Plan has three tiers in its pharmacy program.
- Kaiser Permanente currently has two tiers in its pharmacy program. It is advocating lower prices with pharmaceutical manufacturers as well as policymakers, patient advocates and other stakeholders.
- See page 3 of report for cost share.
- A very small population is using a great percentage of Blue Shield's pharmacy spend. For the period January 1, 2014 through December 31, 2014, Blue Shield's specialty drug spend was 26.2% by 0.5% of its population. See pages 4-5 of report.
- President Scott asked for a dollar amount rather than a percentage of the pharmacy spend.
- Dr. Sipes-Metzler stated that she did not readily have the information but would provide it.
- Specialty drug manufacturing is very complex and requires special handling. It usually requires a different route of administration than through the mouth and is very expensive to produce per unit. Also, a healthcare provider may be required to administer the drug.
- Kaiser Permanente's specialty drug spend was 31.1% from July 1, 2014 to June 30, 2015. See page 6 of report.

- Commissioner Lim asked for the percentage of specialty drug spend for Kaiser's population.
- Dr. Sipes-Metzler stated that she would obtain the information for the Board.
- Specialty drugs are a focus of the Centers for Medicaid and Medicare Services ("CMS"). Hepatitis C has significantly impacted the Medicaid population. Specialty drugs are also causing tension in the health plans because pharmacy is taking money from the medical side.
- The estimate from a number of sources is that specialty drugs could exceed 50% of the pharmacy spend as early as 2018.
- **Surrogate coverage** (Aon Hewitt) – this item was continued to a future meeting.
- **Excise tax update** (Aon Hewitt)
- Anil Kochhar presented an update on Aon Hewitt's January 8, 2015 assessment regarding the Excise Tax impact on high cost employer medical plans starting in 2018.
- Mr. Kochhar summarized that during the last Rates and Benefits process, the Board went through a rigorous exercise in determining how to lower UHC's premium. A subsidy was agreed upon and premium projections were reduced.
- The Affordable Care Act allows blending "similarly situated" pre-Medicare and Medicare retirees, which would eliminate the 2018 Excise Tax. See page 7 of report.
- Aon Hewitt will present its suggestion for blending early retirees and Medicare retirees during the Rates and Benefits process.
- President Scott requested that Aon Hewitt present side-by-side blended and non-blended rates at the appropriate time for the Board's review.

- Commissioner Lim asked when the final policy decision on blending was made. Earlier in the year Aon Hewitt reported that final guidelines had not yet been determined.
- Mr. Kochhar stated that he has been assured by the experts at Aon Hewitt that guidance should be provided in the first quarter of 2016.
- Flexible Spending Accounts ("FSAs") have been included in Aon's projection model calculations. See appendix of report, page 13.
- **Well-being separate contract** (HSS) - this item was continued to a future meeting.
- **Voluntary benefits** (HSS) this item was continued to a future meeting.
- **Choosing Wisely** (Rebeccah Rothschild, Consumers Reports)
- Director Dodd stated that she had been introduced to the Choosing Wisely campaign through PBGH. She thought a presentation to the Board would be helpful since HSS will likely include three of the measures in its vendor contracts next year. She also noted that the California Committee on Reducing Waste and Excessive Cost is using Choosing Wisely measures.
- Rebecca Rothschild, Consumers Reports representative, reported on the Choosing Wisely campaign and Consumer Reports' involvement.
- The Choosing Wisely campaign promotes conversations between patients and providers regarding medical overuse. Such overuse may include antibiotics for upper respiratory infections, opioids for headaches and imaging for low back pain.
- Approximately $750B is spent annually on wasted healthcare. This is a combination of providers offering unnecessary healthcare, patients requesting unnecessary healthcare and television advertising.

- Consumer Reports has a long history of helping individuals make important decisions on the purchase of many items by asking a series of questions. It became involved in the Choosing Wisely campaign to assist individuals make healthcare decisions. In fact, Consumer Reports has been working on healthcare since its first magazine article in 1936 when Alta-Seltzer was tested.
- The Choosing Wisely campaign was developed in April 2012 by the American Board of Internal Medicine Foundation ("ABIM"). ABIM contacted medical societies (radiologists, cardiologists, gynecologists, etc.) across the country and proposed that each come up with five medical tests or treatments that were being performed excessively and state those excessive treatments publicly.
- There are currently over 70 participating medical societies in the Choosing Wisely campaign. Non-medical societies, such as dentists, nurses and physical therapists, are also participating in this campaign.
- There are over 400 topics that the societies have identified around overuse. Consumer Reports has been working on 100 of the identified topics.
- Consumer Reports has been working with all medical societies to determine the need for certain treatments and questions that should be asked to engage in conversations about overuse:
    - What are the risks?
    - Is treatment or testing necessary?
    - Are alternatives available?
    - What are the costs?
    - What if nothing is done?
- If the Health Service Board decides to adopt the Choosing Wisely campaign, three areas of overuse are suggested:

    - Opioid overuse
    - Low back pain imaging overuse
    - Overuse of unnecessary C-sections
- Choosing Wisely has had a huge pick up in mainstream and medical journals. It also works with approximately 70 partner organizations such as AARP, SEIU and many smaller healthcare collaboratives and organizations who are working on Choosing Wisely.
- There are seven grants participating in Choosing Wisely (two are in California). Each has a minimum of two healthcare systems within their grant or a minimum of 14 across the country. Over the next three years, each must decrease overuse by 20% from baseline within their three chosen Choosing Wisely areas. All of these grants are working on antibiotics and respiratory infections in adults, and were allowed to select two other areas.
- Consumer Reports has created Choosing Wisely materials that are free of charge. All of its public health information is free. Posters, wallet cards and other materials are available. Information may also be accessed online. A micro website at a workplace may also be built and rolled out to employees. Consumer Reports can work with specific plans.
- It was recommended that the Board consider adopting particular topics or the five questions if participation in Choosing Wisely is accepted. Working with 400 topics can be very overwhelming.
- Ms. Rothschild noted that while Consumer Reports is working on the consumer side of Choosing Wisely, the ABIM Foundation is also approaching it from the provider side.
- Director Dodd stated that she heard a Choosing Wisely presentation at the Committee to Reduce Overuse. She suggested that perhaps the three topics could

be written into HSS vendor performance guarantees, and incorporate the five questions as well.

- President Scott requested that Director Dodd work with HSS staff to come up with suggestions on how to integrate Choosing Wisely into some of the initiatives being undertaken with members in this current year.
- President Scott also requested attempting to find out how HSS might align with the statewide effort in monitoring certain diagnosis areas.
- Ms. Rothschild reiterated that there would be no cost for HSS participation. All materials from Consumer Reports are free.
- President Scott stated that he would like a report by HSS at the January meeting or February to determine the first step.

Public comments: Richard Rothman, retired City employee, commended the Board on its thoroughness in attempting to hold down costs. He stated that this meeting had been very instructive and expressed relief that the Board was not caving in to pressures.

He also stated that he subscribes to Consumer Reports on unnecessary procedures. He thanked Ms. Rothschild for her presentation.

□ Adjourn: 4:36 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.

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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) 554-0662 or email at laini.scott@sfgov.org.

The following email has been established to contact all members of the Health Service Board: health.service.board@sfgov.org.

Health Service Board telephone number: (415) 554-0662