HEALTH SERVICE BOARD
CITY & COUNTY OF SAN FRANCISCO

Minutes

Regular Meeting

Thursday, April 13, 2017

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
Commissioner Karen Breslin
Supervisor Mark Farrell, excused
Commissioner Sharon Ferrigno
Commissioner Stephen Follansbee, M.D., excused
Commissioner Gregg Sass, excused

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 1:08 pm.

- ☐ 04132017-01 Action item

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

- Regular meeting of March 9, 2017

Staff recommendation: Approve minutes.

Documents provided to Board prior to meeting: Draft minutes.

- Commissioner Breslin moved to approve the regular meeting minutes of March 9, 2017.
- Commissioner Ferrigno seconded the motion.

Public comments: None.

Action: Motion was moved and seconded by the Board to approve the regular meeting minutes of March 9, 2017.

Motion passed 4-0.

☐ 04132017-02 Discussion item

General public comment on matters within the Board's jurisdiction not appearing on today's agenda

- President Scott claimed privilege of the Chair on two agenda items. He reordered agenda item 12 to be presented next. He also asked HSS Acting Director, Mitchell Griggs, to report on a recent staff issue at HSS.
- Acting Director Griggs reported that March was a difficult month for the Health Service System. Vadia Henry, longtime HSS employee, had passed away unexpectedly on March 24, 2017.
- Ms. Henry was hired in March 1980 and worked at HSS as a City Plan claims processor when benefits were administered under the Department of Human Resources. During that time, she became interim supervisor and later a benefits analyst after City Plan's claims administration was transferred to UnitedHealthcare.
- Ms. Henry possessed excellent customer service skills. She was knowledgeable and patient in her interactions with HSS members and had received numerous compliments. She was HSS' Medicare subject matter expert and had worked with Acting Director Griggs on several large claims issues.
- Acting Director Griggs thanked the EAP staff for support during this difficult time of unexpected loss.
- HSS staff had enjoyed working with Ms. Henry throughout the years and will miss her.

- President Scott asked the Board and audience to stand in a moment of silence to honor the life and service of Vadia Henry.

Public comments: None.

RATES AND BENEFITS

☐ 04132017-12 Re-ordered item

Action item

Report and possible action regarding evaluation of search firm RFP respondents and the possible recommendation of a finalist to the RFP for the position of SFHSS Executive Director (President Scott)

Documents provided to Board prior to meeting: None.

- President Scott asked Christina Brusaca, Senior Administrative Analyst with the Department of Human Resources ("DHR"), to update the Board on the HSS Executive Director recruitment.
- Ms. Brusaca reported that DHR issued an RFP for the HSS Executive Director position to a pre-qualified list of recruiters. Three proposals were received and forwarded to the Health Service Board for review.
- President Scott received the proposals and contacted Erik Rapoport, Deputy City Attorney, to ensure compliance with the Brown Act during the recruitment process. He also asked Commissioner Breslin, as Chair of the Governance Committee, to join him in reviewing the proposals.
- Prior to this meeting, President Scott and Commissioner Breslin met to score and identify the firm they would ask DHR to contract with to perform recruitment services. President Scott stated that he would not publicly disclose the name of the firm selected or any other information until a later time and asked Mr. Rapoport to explain.
- Mr. Rapoport stated that the City keeps the negotiation process confidential until a contract is executed. Once the contract is

finalized and signed, the award may be made public.

- President Scott moved that the Board refer the name of the selected RFP candidate to DHR to begin the search for the HSS Executive Director, as well as finalize contract negotiations and proceed in the process as outlined in the RFP response.
- Commissioner Breslin seconded the motion.

Public comments:

Action: Motion was moved and seconded by the Board to refer the selected RFP candidate to DHR for contract finalization and execution in order to commence the HSS Executive Director search.

Motion passed 4-0.

□	04132017-03	Discussion item	Presentation of Aetna life insurance and long term disability insurance rate guarantee for 2018 plan year (Aon Hewitt)

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

- Anne Thompson, Aon Hewitt representative, reported that in April 2016, HSS entered into a three-year agreement with Aetna for life insurance and long term disability insurance. Since the rate lock is in place for the 2018 plan year, no Board action is necessary at this time.

Public comments: None.

□	04132017-04	Action item	Approve Gender Dysphoria benefits for 2018 plan year (Acting Director Griggs)

Staff recommendation: Approve Recommendations and Policy.

Documents provided to Board prior to meeting:

1. Gender Dysphoria Analysis;
2. Draft Gender Dysphoria Benefit Policy Statement;
3. WPATH Position on Medical Necessity.

- Acting Director Griggs reported that last month's discussion on gender dysphoria generated several questions by the Board. HSS compiled a "Gender Dysphoria Analysis" from its All Payer Claims Database ("APCD") on benefit cost information based on diagnosis codes as well as facility inpatient, outpatient, laboratory, etc.
- The total number of gender dysphoria patients for the years 2014-16 are as follows:
    - 2014 – 26 patients
    - 2015 – 46 patients
    - 2016 – 55 patients
- Acting Director Griggs stated that a question arose at the last meeting regarding medical necessity criteria being supplied specifically by Blue Shield and the current gender dysphoria benefits offered. HSS invited a Blue Shield representative to address its medical necessity criteria.
- Anthony J. Van Goor, Senior Medical Director of Policy and Technology Assessment at Blue Shield of California, addressed the Board. He is a board certified specialist in internal medicine.
- Dr. Van Goor commended the Board on its action regarding transgender benefits and stated that he watched the video of last month's meeting. He stated that there are challenging problems related to providing transgender benefits that need to be addressed by a responsible health plan to ensure all beneficiaries are served.
- Dr. Van Goor recited Blue Shield's definition of medically necessary, which is: "A treatment, procedure or drug is medically necessary only when it has been established as safe and effective for the particular symptoms or diagnosis, is not investigational or experimental, is not being provided primarily for the convenience of the patient or the provider, and is provided at the most appropriate level to treat the condition." He noted that Blue Shield's statement of medical

necessity is simpler than the AMA statement and the World Professional Association for Transgender Health "(WPATH") statement.

- Dr. Van Goor has been dealing with medical necessity for the past 24 years and stated that it has been a challenge in understanding how to apply them to individual cases. It involves assessment of the needs of the patient as well as the safety and effectiveness of the procedure being considered. Medical necessity is a concept very well adapted to physical issues and illnesses. However, in dealing with social, professional or personal issues and acceptance in society, medical necessity criteria does not work as well.
- The principle benefit to transgender surgery is that it helps with the individual's identity. It is not only physical, but emotional, psychological and spiritual.
- When Blue Shield receives a request for transgender benefits, a nurse review takes place and the request is sent to a medical director for review. The medical director gathers all available information. Assistance is available if the medical director cannot make a determination on an ancillary procedure. Plastic surgeons are consulted and very often independent reviews by surgeons or other specialists outside Blue Shield are made. If Blue Shield cannot make a determination, its policy is to err on the side of the patient and make sure the procedure is carried out.
- The California Reconstructive Surgery Act of 1998 states that if a medical condition is caused by disease, trauma or congenital defect, the health plan will consider either one of two characteristics in making a medically necessary decision. One is appearance and the other is function.
- In 2014, the DMHC established a policy that gender dysphoria would be considered a disease in relation to the California Reconstructive Surgery Act. Because it is

difficult to interpret, requests under the Act are reviewed by Blue Shield's medical director.

- Dr. Van Goor stated that in looking at Kaiser Permanente's presentation last month, he saw very little difference from Blue Shield's practice in considering reconstructive surgery for transgender patients.
- Dr. Van Goor commended the Board for looking at medical necessity as it has been an issue that Blue Shield has been struggling with for years.
- Acting Director Griggs introduced Theresa Sparks, Senior Advisor on Transgender Initiatives in Mayor Lee's office. She is former Executive Director of the Human Rights Commission, President of the Police Commission and Mayor Willie Brown appointee to chair the LGBT Advisory Committee of the San Francisco Human Rights Commission.
- Ms. Sparks stated that she had never heard a presentation as complete as Dr. Van Goor's, stating that it was very well done. When the Health Service Board adopted the non-discrimination policy 20 years ago, there was almost no science and very little art. Some of the cost considerations at the time were overinflated, which was discovered a few years later when the services were found to be substantially less expensive.
- Last year under Healthy San Francisco, approximately 70 individuals had bottom and top surgeries. San Francisco is seen as a transgender center of health excellence at the Parnassus campus, which has also conducted extensive research.
- Benioff Children's Hospital in Mission Bay has a gender youth clinic and last year counseled 350 families about gender dysphoria issues with children between the ages of 6 and 12.
- There are issues other than science and many definitions are not intuitive. There is the gender one is assigned at birth and the

label and gender that follows one their entire life, based on physical appearance. The other is gender identity.

- Two big issues are being looked at that are relatively costly—facial feminization surgery and breast reconstruction surgery. When Ms. Sparks was Director of the Human Rights Commission, they filed a complaint against the Health Department because it provided breast reconstruction surgery based on criteria for women with cancer who had lost their breast but would not provide the same services for transgender individuals. CCSF lawyers saw the policy as discriminatory since both conditions were based on self-esteem, physical appearance and how a woman felt about herself.
- Ms. Sparks stated that she is the first transgender person to directly advise a mayor and Board of Supervisors on this issue.
- Acting Director Griggs stated that he wanted to ensure that the Board received answers to its questions regarding medical necessity as well as put into context the reason transgender benefits paid for by the health insurers as well as an employer. He committed to continuing the work.
- Recommendations were presented at last month's meeting and were presented for the Board's approval at this meeting:
- Approve the San Francisco Health Service System Gender Dysphoria Policy statement;
- Recommendation 2: Eliminate the $75,000 lifetime cap for gender dysphoria benefits in the fully-insured UnitedHealthcare Medicare Advantage Plan.
- Recommendation 3: Require all plans to adopt the approach taken by Blue Shield currently for gender dysphoria benefit plan offerings and eliminate cosmetic exclusions for gender dysphoria treatments (see Gender Dysphoria Analysis, Recommendation 3 for list of services). Also to ensure consistency,

to require all plans to review for medical necessity treatments.

- Acting Director Griggs suggested that the Board approve the above recommendations.
- Commissioner Lim moved to approve the gender dysphoria benefit plans for 2018 in recommendations 1, 2 and 3.
- Commissioner Breslin seconded the motion.
- President Scott acknowledged a letter addressed to Health Service Board members received that morning from the Union of American Physicians and Dentists expressing support for all HSS provided medical plans to be updated and standardized in order to cover medically necessary treatment for gender dysphoria.

Public comments: Kate Kessler, Kaiser Permanente Vice President, invited Dr. Bill Plautz to comment on this topic.

Dr. Plautz stated that he was an emergency physician at Kaiser Permanente and as the health plan's physician advisor, is also involved in Kaiser's transgender program and decisions regarding benefits. He stated that the comments of Dr. Van Goor and Ms. Sparks were very much in concordance with Kaiser Permanente's views. He stated that Kaiser is committed to providing compassionate and high quality care for its transgender members. He acknowledged and stated that Kaiser practices the WPATH standards and that practitioners provide any and all medically necessary treatments by the definitions presented today without discrimination with respect to race, ethnicity, age, gender or gender identity. Kaiser provides medically indicated treatments including reconstructive surgery statute presented today. Patients are treated to the extent possible to create a normal appearance for the gender they identify with. Kaiser has a clear standard that is defined in the State of California by the Affordable Care Act, section 15.57 and is applied consistently.

Dr. Plautz also sits on Kaiser's Oversight Committee for Transgender care and participates in weekly statewide member issues resolution calls for

transgender patients. He stated that he believes that Blue Shield is applying the same standards as Kaiser Permanent.

Emma Erbach, Local 21 representative, thanked the Board for taking up this issue and expanding the range of options for transgender members. Local 21 continues to talk with the City about being an employer of choice. It is great ot see San Francisco continue to uphold its well-deserved reputation for being a city not afraid to stand up for what is right even when other parts of the country are not doing anything.

Action: Motion was moved and seconded by the Board to approve the gender dysphoria recommendations 1, 2 and 3 for the 2018 plan year.

Motion passed 4-0.

□ 04132017-05 Discussion item

Presentation of Vision Service Plan's buy-up option

(Vision Service Plan)

Documents provided to Board prior to meeting: Report prepared by VSP.

- Lucinda Ward, VSP Regional Vice President, reported on a new vision buy-up plan option for all active and retired HSS members.
- The vision buy-up option would allow members to purchase glasses or contacts annually instead of every 24 months, which is the current plan. Under the buy-up plan, the frame allowance would increase from $150 per year to $300. The contact lens allowance would increase from $150 to $250. (See page 3 of report for the core plan versus the proposed buy-up plan and rates.)
- HSS would continue to pay $3.95 PMPM for the core vision plan. HSS members wanting the buy-up option would pay the difference.
- Under the buy-up option, two administration methods are under consideration—HSS in-house administration or VSP administrative services:
    - HSS Administered monthly cost: $9.36 PMPM

- VSP Administered monthly cost: $10.86 PMPM.

- Commissioner Breslin stated her preference that VSP administer the buy-up option since HSS staff is already extremely busy.

Public comments: Dennis Kruger, representative for active and retired firefighters and their surviving spouses, asked how the monthly funds for the buy-up option would be deducted regardless of who administers the plan, i.e., payroll deduction or monthly bill. He also asked for clarification on the frame allowance at Costco, stating that the amount should be identical across the board.

□ 04132017-06 Discussion item Presentation of risk scores (Marina Coleridge)

Documents provided to Board prior to meeting: Report prepared by SF Health Service System.

- Marina Coleridge, HSS Data Analytics Manager, presented the risk scores for HSS actives and early retirees. She noted that HSS' all-payer claims database ("APCD") was used to compile the information. Last year's report was presented in June, however, future data will be available during the rates and benefits cycle.

- As an actuarial tool, risk scores are used to predict costs in healthcare, taking into account age, gender and diagnoses. (See report page 2-10 for specific plan data.)

- Ms. Coleridge reported that on average, this analysis is good news for HSS as the risk scores improved slightly over the last period and are lower than data previously presented.

- Commissioner Breslin asked how HSS' membership compared to other groups, such as CalPERS.

- Ms. Coleridge stated that she was unaware of CalPERS' risk scores but that she could present the California benchmark using the market scan database next month.

Public comments: None.

□ 04132017-07 Discussion item Report on specialty pharmacy trends (Aon Hewitt and HSS Medical Providers)

Documents provided to Board prior to meeting: Reports prepared by Aon Hewitt, Kaiser Permanente UnitedHealthcare and Blue Shield.

- Paige Sipes-Metzler, Aon Hewitt, reported that she was joined by HSS medical providers Kaiser Permanente, UnitedHealthcare and Blue Shield, who would each present on specialty pharmacy trends.
- Dr. Sipes-Metzler reported that specialty medications are compounds and typically biologic in nature. They require spatial manufacturing, such as cold temperatures, sterility and things of a nature that one would not find in normal medications. Specialty medications are also very high cost; they can average $3,000 per month. She noted that there is one drug that treats a hereditary disease that can cost $1M per year.
- Specialty medications can also cause significant side effects and, therefore, require clinical management.
- Currently, 2-3% of HSS members use specialty medications. By 2020, that percentage is expected to approach 50% of HSS' pharmacy spend.
- Dr. Sipes-Metzler stated that at this point in time, there are no replacements for specialty medications and the process is slow to gain approval.
- In 2013, the FDA first approved two medications for cystic fibrosis, followed by Hepatitis C medications. In 2014, specialty drug prices increased by 30%. Costs continue to increase for inflammatory diseases such as diabetes, oncology, MS and HIV. As more individuals are required to take these medications, costs will continue to balloon. (See pages 5 and 6 of report.)
- Kaiser Permanente –Dean Fredriks, PharmD, Director of Drug Use Management, and Scott

Yamaguchi, Underwriting Vice President, addressed the Board.

- Dr. Frederiks reported on Kaiser Permanente's strategies for controlling prescription drug costs. While Kaiser Permanente is not immune to rising drug costs, it utilizes an integrated system to manage prescription drug prices; its process is physician driven to lead to the best outcomes.
- One of Kaiser's strategies is its ability to shift market share within its organization to negotiate the best prices with manufacturers on an ongoing basis.
- Kaiser has implemented a specialty tier for prescription drugs to remain competitive in the market. It is also involved in advocacy around rising drug prices at the government level with a threefold message:
    - transparency in drug pricing
    - competition to decrease prices
    - added value with price increases
- Kaiser is expanding existing tools and implementing new tools to address specialty drugs.
- Scott Yamaguchi stated that specialty pharmaceuticals are a challenge for the entire healthcare system. He noted that Kaiser Permanente's comprehensive program has demonstrated results over time and continues to expand and evolve to stay current and manage specialty drug issues. Kaiser's strategy is broader than the clinical components that comprise benefit design, procurement and purchasing and its advocacy role. Kaiser's clinical management programs and clinicians are the core of its integrated model, which is a key differentiator in providing services.
- Mr. Yamaguchi referenced the table at the bottom of page 5 of Kaiser's report, which showed historical cost trends of the HSS membership from 2012 through 2016 and

the compound annual growth rate for this time period.

- President Scott asked Dr. Sipes-Metzler for an estimate of the total dollar amount spent annually on specialty drugs by all vendors.
- Dr. Sipes-Metzler responded that she could not report the exact amount spent annually on specialty drugs but that she would return with the answer at the next meeting.
- UnitedHealthcare – Bonnie Hayes, Optum Rx representative, addressed the Board. Optum is UnitedHealthcare's pharmacy provider. The information presented was specific to HSS members.
- Ms. Hayes reported that, of the $7M total pharmacy costs through Optum Rx, nearly half of that amount was for specialty drugs. She referenced the four-year trend analysis (2013 through 2016) on the first page of her report at 4.3%. The specialty trends for 2014 and 2015 were driven by new Hep C drugs at an average cost of approximately $30,000 per month or $100,000 per therapy with a success rate of approximately 95%. A negative spend was reflected for the four-year period in non-specialty drugs (i.e., cholesterol, diabetes).
- Ms. Hayes noted that HSS' generic drug utilization represents only 18.7% of the cost (i.e., $36 for generic drugs versus $340 for a brand). On the other hand, specialty drug utilization is driving 45.1% of the cost, which is higher than Optum's other plans (approximately 35%). The industry expectation is 50% of the overall cost in a few years. (See page 3 of report.)
- Ms. Hayes also reported on BriovaLive, Optum's specialty pharmacy. It not only provides assistance to members facing serious diagnoses, but also includes materials for family caregivers to connect to the BriovaLive community for education. Facetime with a nurse or pharmacist is a major feature of BriovaLive.

- Ms. Hayes stated that Optum negotiates for the best rebates. She identified an error at the bottom of page 6 under "Historical Rebate." The estimated rebates for 2016 is $893,000 and not $89,300 (the comma was misplaced).
- President Scott asked if the $893,000 rebate was the amount of money to be returned to HSS.
- Ms. Hayes responded affirmatively.
- Commissioner Breslin stated that transparency was the number one issue at a benefits conference that she recently attended. The panel also discussed rebates and suggested that drug prices are inflated and the extra money is returned.
- Ms. Hayes stated that Optum does not play the price setting game and does not put the highest cost drugs on the list for rebates.
- President Scott stated that he had attended the same conference as Commissioner Breslin and that he would make comments during the President's report.
- Blue Shield – Jeanette Mone, Blue Shield Account Manager addressed the Board.
- Ms. Mone stated that HSS' largest prescription trend occurred in 2014 at 23.93%. See page 2 of report.
- The average specialty drug cost is $6,350 per month. The cost share for HSS members is 20% with a cap of $100 per 30-day fill.
- HSS specialty costs are 14% higher than the benchmark for similar employers and have increased 26% year over year.
- Blue Shield's specialty prescription programs are not focused on rebates. It has tiered professional fee schedules and offers incentives to medical practitioners for prescribing lower cost drugs. It also provides nurse and practitioner support to members in advance of fills.

- Blue Shield also offers a short cycle program for members unable to take an entire course of specialty drug prescriptions. The first scripts are filled for 14 to 16 days and the member's copay is prorated accordingly.
- In closing, Dr. Sipes-Metzler recommended that a specialty formulary be developed and determine how to tier the program, given the discrepancy between the total cost of the drug and the member's out-of-pocket. She also encouraged including partial fills for the initial prescription.

Public comments: None.

□	04132017-13 Re-ordered item	Action item	Approve Revised San Francisco Health Service System Trust Fund Investment Policy Statement (President Scott) Documents provided to Board prior to meeting: Revised Investment Policy Statement. ▪ President Scott commended the work of Deputy City Attorney, Erik Rapoport, who led the legal review of the SFHSS Trust Fund Investment Policy recently approved by the Board. He noted, however, that one final revision was necessary--the deletion of one errant phrase on the top of page 6. ▪ Commissioner Breslin moved to approve the Investment Policy as edited. ▪ Commissioner Ferrigno seconded the motion. Public comments: None. Action: Motion was moved and seconded by the Board to approve the revised San Francisco Health Service System Investment Policy Statement as edited. Motion passed 4-0.
□	Meeting Break		Recess from 3:10 to 3:17.
□	04132017-08	Discussion item	Presentation on Kaiser Permanente's multi-region plan (Kaiser Permanente) Documents provided to Board prior to meeting: Report prepared by Kaiser Permanente. ▪ Cindy Green, Kaiser Permanente Executive Account Manager, reported on the possibility of extending Kaiser coverage to early retirees and Medicare retirees living outside California. ▪ HSS is evaluating contracting with three Kaiser Permanente regions outside California to offer another choice for early retirees and retirees: Oregon, Washington and Hawaii. HSS would need to add three separate contracts in order to allow expanding Kaiser Permanente's services in those states. (See pages 4 and 5 of Kaiser's report for regional information and eligible members.)

Kaiser's California-based account team would remain HSS' sole contact for administrative and eligibility contract needs in other regions.

- Kaiser is currently in the bidding process and asking for rates and benefits. It hopes to align benefits as closely as possible to home regions; however, the Department of Insurance in those areas may prohibit an exact matching of benefits with the State of California. Kaiser's goal is to match the home regions as closely as possible.
- Ms. Green noted that under CMS regulations and guidelines, early retirees and Medicare retirees would need to complete a new enrollment form if they reside outside California; they cannot continue the same enrollment arrangement.
- If HSS decides to move forward with contracting in the three states, Kaiser will also evaluate the administrative impact on HSS staff and the Kaiser Permanente account management team of adding three contracts. Kaiser wants to ensure continuous delivery of high quality service.
- In addition to custom contracts with the proposed regions, a separate evidence of coverage ("EOC") will be established. Additional group numbers would be created for the new regions.
- Kaiser Permanente is also looking at the impact on the current eligibility file. It would be necessary to create separate files for the new regions.
- The effective date for expansion into the three new regions is January 1, 2018.
- Commissioner Breslin asked about expanding into Colorado (one of Kaiser's service regions). She also inquired whether retirees currently in the UHC Medicare Advantage plan could transfer to Kaiser in those regions.
- Ms. Green stated that Kaiser chose to start with the three most populous regions in order to evaluate the administrative impact. She noted that Kaiser Permanente would be a

medical choice during open enrollment for retirees wanting to move from UHC to Kaiser.

Public comments: Dennis Kruger, representative for active and retired firefighters and surviving spouses, expressed support for Kaiser's expansion for retirees.

Claire Zvanski, RECCSF representative, also expressed support for the expansion of Kaiser's services into the three regions, especially Hawaii and Oregon. She receives inquiries on this subject often and expects that the numbers would increase over time. She also expressed hope there would be a way to have the early retirees and retirees rated in a larger group to keep the rates down for members moving out-of-state. She noted that keeping the rates affordable is important because if benefits become more expensive than UHC, it may defer members from moving to and/or maintaining long history with Kaiser.

□ 04132017-09 Discussion item

Presentation of Healthcare Value Initiative ("HVI"), which compares benefits across governmental and private sectors (Aon Hewitt)

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

- Anne Thompson, Aon Hewitt Vice President, reported on Aon's Health Value Initiative ("HVI"), which has been presented to the Board for several years.
- The HVI is a comparison of HSS' active population against Aon's database (9.3 million participants).
- HSS pays approximately 86% of the total cost of healthcare versus the benchmarks for the public sector. Its members pay approximately 10.1% of premiums compared to 31.4% of the public peer group. HSS members pay $612 versus an average of $1,441 for public sector.
- Ms. Thompson reported that the overall comparison from 2016 versus 2017 for HSS and versus peers is very positive.

Public comments: None.

REGULAR BOARD MEETING MATTERS

□ 04132017-10 Discussion item **President's Report** (President Scott)

Documents provided to Board prior to meeting: California Healthline article: Justice Department joining lawsuit alleging Medicare fraud by UnitedHealth (March 28, 2017).

- President Scott reported on his attendance at the Integrated Benefits Institute Forum held in San Francisco recently. In addition to Commissioner Breslin, Lee Hagy, HSS Research Assistant was also in attendance.
- HSS' Well-being program received an Enterprise Health Management and Performance award which allowed free access to the forum for those who attended.
- President Scott stated that while some sessions were somewhat repetitive, he found the Forum informative.

Public comments:

□ 04132017-11 Discussion item **Director's Report** (Acting Director Griggs)

- HSS Personnel
- Operations, Data Analytics, Finance/ Contracting, Communications, Well-Being/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, Well-Being and Employee Assistance Program;
3. "Misdiagnosis is more common than drug errors or wrong-site surgery," The Washington Post (May 6, 2013);
4. Quarterly Wellness Center Report;
5. Revised Rates and Benefits calendar.

- Mitchell Griggs, HSS Acting Executive Director, presented the Director's report, which may be viewed on the myhss.org website.
- HSS has hired Megan McCarthy as a temporary employee to scan all of the department's contracts for digital copies.
- HSS hosted a retirement event in its Wellness Center for Catherine Dodd, former Director, on March 13. Approximately 100 people were in attendance and 12 spoke about her service to the City and HSS. Dr. Dodd's last day of employment was March 14, 2017.
- The Wellness Center was renamed as the "Catherine Dodd Wellness Center" to honor Dr. Dodd. New plaques were on order and will be installed.
- Acting Director Griggs asked Stephanie Fisher, Well-being Manager to present an update on the Well-being Program.
- Ms. Fisher reported that the Well-being Program incorporates all members, employees and retirees, as well as the Wellness Center. She provided an update on the Department Head meeting, employee champion recruitment and training, and the upcoming campaign: Play Your Way.
- The Play Your Way campaign will run from April through June and the 30-Day Challenge will run in May. All HSS members are eligible to participate. Sign up on myhss.org/well-being.
- The Wellness Center will host "Play Your Way" week April 24-28. HSS is encouraging departments to visit the Wellness Center for a 15-minute energizing break. On April 26, from 11am to 2pm, HSS will hold a fitness fair at which members can learn about resources offered to them through their health plans.
- Ms. Fisher encouraged the Board to review the remaining data on the Wellness Center usage and group exercise on their own.
- Commissioner Breslin asked when the Board could expect to receive a report on whether

the wellness activities are actually making members healthier.

- Ms. Fisher stated that she could compile a presentation from the 2014 wellbeing assessment data compared to the 2015 data, which shows lower costs for members with improved well-being. HSS has data that shows its population's well-being is improving. She noted that HSS chose not to make assessments in 2016 and 2017 because a lot of money and time had been spent previously on collecting data and not helping members improve their well-being. The current focus is on programming and creating a culture that can be sustained.
- President Scott asked if the next Well-being quarterly report could contain a high level summary of beginning statistics and improvements made to date, supported by data. He suggested measuring the data on a two-year cycle instead of annually.
- Acting Director Griggs stated that the work on the self-service part of e-benefits had begun. Regular meetings had been scheduled and several key staff members were working to roll out a pilot of self-service benefits in October 2017. E-benefits will allow members to electronically enroll, change benefits and/ or add/drop dependents.

Public comments: Dennis Kruger, representative for active and retired firefighters and surviving spouses, stated that if walking through the North Court prior to the Board meetings is any indication, then the Wellness Program is working. He sees 50 or so people each time exercising in the North Court.

Claire Zvanski, RECCSF representative, stated that based on a previous presentation, she thought there would be no HIT tax and the Cadillac tax through the ACA was postponed until 2020.

Acting Director Griggs stated that the HIT tax does exist but does not affect Blue Shield (self-insured) as previously reported. It will still impact the insured plans.

□ 04132017-14 Discussion item **HSS Financial Reporting as of February 28, 2017**
(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, reported that the trust fund projection for June 30, 2017 is $73.5M, which is $1.1M higher than the amount reported in February. This change is due to favorable claims experience for the self-funded City Plan and Delta Dental.
- Pharmacy rebates in the amount of $140,000 were received in February; however, the year-end projection remains unchanged since the amount was anticipated.
- Two applications had been received for surrogacy and adoption. One applicant had been deemed eligible for the benefit and payment would be issued within the next few weeks. The second application was still under review.
- The budget was still under review at the Mayor's office; there was nothing new to report. She anticipated that the HSS budget would be finalized with no cuts; however, until it is published, the budget is not final.
- Commissioner Breslin stated that while the Board had begun receiving reports on the surrogacy and adoption benefit, it has not received a report on the performance guarantees for this year. She asked how much was set aside for surrogacy.
- Ms. Levin stated that $300,000 had been earmarked for surrogacy and adoption together. Because the reports are made on a fiscal year basis, only $150,000 was put in the budget for January 1, 2017. For fiscal

year 2017-18, an additional $150,000 will be added.

- Commissioner Breslin stated her interest in the performance guarantees, which pay for the surrogacy and adoption benefit and how they are tracked in the fund balance.
- Ms. Levin stated that the performance guarantees are deposited into the trust fund and are not segregated.
- Commissioner Lim suggested tracking the funds for surrogacy and adoption from performance guarantees beginning with Fiscal Year 2016-17 and the difference will go to the fund balance.
- Ms. Levin stated that she would be able to track the performance guarantees as requested.

Public comments: None.

□ 04132017-15 Discussion item **Report on network and health plan issues (if any)**
(Respective plan representatives)

- Kate Kessler, Kaiser Permanente representative, reported on an account management change. Cindy Green has been promoted within Kaiser and is now Director of Strategic Accounts. HSS' new Account Manager is Patricia Purvis, who has been employed by Kaiser for 20 years. Ms. Green will work with Ms. Purvis for the next several months for a smooth transition.
- Commissioner Breslin asked that all health plans report on their current nutrition counseling benefits and plans for future nutrition counseling to be provided since that information was requested several months ago.
- President Scott asked Acting Director Griggs to obtain a consolidated report for all of the plans to be presented at the next meeting.
- Commissioner Breslin also asked for a UHC representative to respond whether a doctor's referral for physical therapy is required in the Medicare Advantage Plan.

- Shannon Haas, UnitedHealthcare representative, stated that a doctor's referral for physical therapy should not be required for Medicare retirees. She stated that she would follow up on the issue.

Public comments:

□	04132017-16	Discussion item	Opportunity to place items on future agendas Public comments: None.
□	04132017-17	Discussion item	Opportunity for the public to comment on any matters within the Board's jurisdiction Public comments: Ann Donlan, Communications Director at San Francisco Superior Court, stated that she wanted to make the Board aware of extremely poor service that she received from EBS. She noted with interest the reports on many customer service metrics and measurements for HSS and urged the Board to require the same for EBS. She suggested that the Board seek feedback from members on EBS' customer service to make sure that it deserves the City's business. She stated that EBS had failed in the simplest of tasks, such as accurately entering payroll deductions, making customer service representatives accessible, responsive and effective at problem solving. She requested that the Board undertake an evaluation of EBS' performance to determine the level of customer satisfaction. She stated that in her nine years of employment, she could not recall any customer service surveys conducted for EBS. She also noted that a simple Google search would show that her experiences are not unique. She was in possession of nine EBS reviews posted on Yelp and each one provided a one-star rating (the lowest possible).
□	04132017-18	Action item	Vote on whether to hold closed session for member appeal (President Scott) Staff recommendation: Hold closed session. ▪ Commissioner Breslin moved to hold a closed session to hear a member appeal. ▪ Commissioner Lim seconded the motion.

Public comment on all matters pertaining to the closed session: None.

Action: Motion was moved and seconded by the Board to hold a closed session to hear a member appeal.

Motion passed 4-0.

Closed session pursuant to California Constitution Article I, Section 1; the Confidentiality of Medical Information Act, California Civil Code §§56 et seq.; and the Health Insurance Portability and Accountability Act, 42 U.S.C. §§1320d et seq.

□ 04132017-19 Action item

Member appeal (President Scott)

Staff recommendation: Uphold HSS decision.

Documents provided to Board prior to meeting:

1. Memo from HSS;
2. Supporting documentation from member to Health Service Board.

Reconvene in Open Session

□ 04132017-20 Action item

Vote to elect whether to disclose any or all discussion held in closed session (President Scott)

- Commissioner Breslin moved to not disclose any of the conversation held in closed session.
- Commissioner Lim seconded the motion.

Public Comments: None.

Action: Motion was moved and seconded by the Board to not disclose any of the discussion held in closed session.

Motion passed 4-0.

□ 04132017-21 Action item

Possible report on action taken in closed session (President Scott)

- Commissioner Breslin moved to not report on action taken in closed session.

- Commissioner Lim seconded the motion.

Public Comments: None.

Action: Motion was moved and seconded by the Board to not report on action taken in closed session.

Motion passed 4-0.

- Adjourn: 4:34 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.