HEALTH SERVICE BOARD
CITY & COUNTY OF SAN FRANCISCO

Draft Minutes

Regular Meeting

Thursday, August 9, 2018

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 Karen Breslin
Vice President Stephen Follansbee, M.D.
Commissioner Wilfredo Lim
Commissioner Sharon Ferrigno
Commissioner Randy Breslin
Supervisor Rafael Mandelman

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 1:00 pm.

□ 06142018-01 Action item

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

- Regular meeting of June 14, 2018

Staff recommendation: Approve minutes.

Documents provided to Board prior to meeting: Draft minutes.

- Commissioner Breslin moved to approve the regular meeting minutes of June 14, 2018.

- Commissioner Ferrigno seconded the motion.

Public comments: None.

Action: Motion was moved and seconded by the Board to approve the regular meeting minutes of August 9, 2018.

Motion passed 6-0

☐ 06142018-02 Discussion item **General public comment on matters within the Board's jurisdiction not appearing on today's agenda**

Public comments: None.

☐ 06142018-03 Discussion item **President's Report** (President Breslin)

Documents provided to Board prior to meeting: None.

- President Breslin welcomed the new Board member Rafael Mandelman, who was appointed by the Board of Supervisors.
- President Breslin thanked Anthony Gan for working with the Board as the interim Board Secretary, it was acknowledged that this is a big piece of the Board's process. President Breslin thanked Anthony for his help.

Public comments: None

☐ 06142018-04 Discussion item **Director's Report (Executive Director Yant)**

- Executive Director Yant explained that today's meeting would cover the initial ideas for the HSS Strategic Plan.
- Executive Director Yant stated that HSS' rates and benefits from last year culminated full approval with the Mayor's Office and the Board of Supervisors.
- Open Enrollment this year is expanding to a wider net of self-enrollment, to about 14,000 members. This open enrollment pool will include retirees and active employees.
- Executive Director Yant explained that HSS completed a retiree wellbeing survey, and those numbers are being processed. There were 2757 retirees who responded, so

there will be a presentation on that data soon.

- HSS is in the final stages of a member audit that identified members with dependents and asked the members to share current proof of relations so that the dependent could retain the benefits. If the member did not submit proof the dependent was dropped from the plan
- Executive Director Yant stated that our service team members are continually working with the members for verification purposes. 166 member's dependents have been verified in the past week.
- Executive Director Yant stated that we are on the final stages of this audit, and the hope is to conduct verifications on a more regular basis. We have been working with the Unions in hopes to resolve these types of issues with a regular process being implemented.
- Commissioner Lim: For the non-response members – we have a lot of CCSF employees with current mailing addresses, but what about our retirees, who may live out of the country or out of state.
- Executive Director Yant stated that we have been sending notices to the addresses we have on file, multiple notices if needed. HSS has also been working with the Retirement Associations so that they can also help deliver the messages.
- Executive Director Yant also stated that there is an open appeal process for the members to give the proper verification, and if the member misses that window than some of those appeal cases will come to the Board.
- Commissioner Lim suggested that HSS reach out to the Retirement system to coordinate as they may have updated addresses.
- Executive Director Yant noted that in the past the Retirement system does not share addresses with HSS because of their privacy rules.

- Executive Director Yant presented the promoted staff to the Board: Megan McCarthy and Jesse Franklin. She also mentioned the newest members of the HSS staff to the Board: Matthew Probae and Geraline Serdo-Lopez. Finally, Leticia Pagan was introduced as the new Senior Health Planner. It was also mentioned that a new Board Secretary would be starting in late August 2018.
- Commissioner Scott mentioned that there is a list regarding the number of items that are being followed up on- one of the items is the City Plan—I know that we are going through the renewal but there are some drastically different things going forward.
- Executive Director Yant explained that these items are being put into the context within the strategic plan. HSS will be operationalizing some of the items during the strategic planning process.
- The items that have been brought forward by members of the publicly and we have been tracking them.
- President Breslin asked about Proposition B, and if there was anything to discuss at this meeting.
- Executive Director Yant responded that we as a Health Service System know that Proposition B was passed by the voters in 2009 and this changed the rules of eligibility for retirees as it relates to their health benefit.
- Executive Director Yant noted that there has been some challenges and unique experiences for some of the retirees under this legislation. HSS has been working with the Retirement system, the department of human resources, the city attorney, and our own teams to help members with their eligibility questions. We are also working on our processes and procedures regarding these issues/questions.
- Executive Director Yant mentioned that HSS has encountered some issues with retirees in the past and HSS anticipates future needs of the retirees in the future. Currently,

we are working with a retiree on a case by case basis.

- President Breslin thanked Executive Director Yant for her insights, and then asked for any final public comments or thoughts.

Public comments:

President of the RECCSF, Clair Zvanski thanked Executive Director Yant for her presentation to the retirees, as well as an informative presentation from UHC.

President Zvanski of RECCSF mentioned that the retirees have been experiencing similar issues about eligibility and dependents prior to the 2008 legislation changes. Another layer of the retiree issues stem from people's life changes- like moving or the dependent they thought was covered and is actually not when they go for a treatment.

SFERS is doing its own audit on its retirees and its teachers as well. President Zvanski of RECCSF mentioned that her asscoiation is trying to inform all the retirees that there are multiple audits happening to reduce confusion. This happens every 5 years.

President Zvanski of RECCSF noted that these audits have a history and thanked Executive Director Yant for her presentation again.

☐ 06142018-05 Discussion Item

HSS Financial Reporting as of May 31, 2018 (Executive Director Abbie Yant)

Documents provided to Board prior to meeting: Financial Update Memo

- Executive Director Yant offered to read the comments for the report in Pamela Levin's absence. It was stated that this report is a summary of actual revenues and expenses of the employee benefit fund.
- Executive Director Yant stated that the trust projection on 6/30/2017 was $72.5 million and by 5/2018 the fund balance was $72.9 million. This increase is primarily based in UHC's claim experience. Pharmacy rebates

are also part of this increase. It was mentioned that there was a decrease in funds on the Trio plan at about 4.8 million. There have been favorable dental plan claims.

- As of 5/31/18 HSS paid $99,000 under the adoption and surrogacy assistance- this also includes 76,000 in the fiscal year '17-'18.
- Executive Director Yant stated that the general fund administration budget will have a year end balance of $419,000 primarily in the savings of salaries and fringes.
- President Breslin thanked Executive Director Yant and asked for public comment or thoughts.

Public comments: none.

☐ 06142018-06 Action item

Approval of Revisions to Health Service System Membership Rules (Mitchell Griggs)

Staff recommendation: Approve updates.

Documents provided to Board prior to meeting: Summary of Changes and Draft Membership Rules

- Mr. Griggs noted that annually the HSS brings the membership rules to the board as notification so HSS can move these rules from one year to the next.
- These rules are made public so that the public is aware of any changes in these rules.
- Mr. Griggs stated that this year there are not any changes being made to the rules, so technically these are the same rules that were used in 2018 as far as eligibility and enrollment go. These rules are just moving to 2019.
- All clerical or slight clarifications except for the very last one in appendix A where we are listing the benefit coverage periods for 2019 but it happens to be the same as 2018. It's the by-weekly payroll weeks or monthly depending on what the employer or the employees pay periods are.

- Commissioner Scott asked if these rules would be posted to the website once they are adopted. He also wondered how long it would take for the rules to be available online
- Mr. Griggs confirmed that the rules would be available when the enrollment begins for the year 2019, which begins in October 2018.
- Commissioner Follansbee, MD, asked about Item G on the rules, and he asked for some clarification on what sections “significant events” would be applicable as it seems to relate to various parts of the document. “Significant events” seem to be qualifying events. Commissioner Follansbee wanted to know if members need to read the whole definition for section G or if there was a simpler section to review.
- Mr. Girggs clarified the section G does apply to all the qualifying events that we have out there for member changing, dropping dependents or an enrollment.

Public comments: none

Motion passed 6-0.

☐	06142018-07	Discussion item	Presentation of SF HSS All Payors Claim Database (APCD) Demographic, Utilization, and Quality Dashboard (Marina Coleridge)

Documents provided to Board prior to meeting:

- SFHSS APCD Express Dashboard
- CCSF Medicare Dashboard
- CCSF Non-Medicare Dashboard

Ms. Coleridge is the Enterprise Systems and Analytics manager. The express dashboard explores the cost utilization for the full 2017 calendar year. This dashboard was rolled out August 2018- this system allows our all-payer claims database to pull information from systems and conduct ad hoc analysis.

- These analysis influence and inform our decisions and member plans with a holistic view of the populations we serve through the data collected compared to the reports we receive through the health plans.
- There are two dashboards – Medicare populations and non-Medicare populations
- Some of the key observations as we looked at this dashboard are our City Plan non-Medicare population did have a slightly lower risk score over previous year and that was in part from some of the increase in subscribers.
- specialty drugs, they comprise 14 out of the 15 when we look at our top drug spend and 8 of those drugs are used for HIV infection and will account for 18% of our costs.
- Diabetes is our third most prevalent chronic condition and our costliest chronic condition in our active and early retiree population.
- Autism as our top mental health condition. We currently have 214 patients which range in age from 1 to 49. (Advocates are working to reclassify Autism as a developmental and neurological disorder)
- The first page of the Dashboard houses a high-level overview of our population and demographics. Risk scores are included on the demographics page, as well as high cost claimants.
- The next page shows some of the care settings, and here we look at in inpatient care, outpatient, mental health, your lab rad, your radiology, and your other professional services. This also includes prescription drugs.
- We use this data to track cost and utilization trends. Here we have a benchmark, so we can get a sense of the performance of our population to others, what's available to us in the Truven market scan database as a western norm. (This benchmark is based in PPO data)

- President Breslin asked if Blue Shield was higher than the City Plan for high cost claims-
- Ms. Coleridge explained that “the total dollar amounts much higher in Blue Shield and Kaiser because we've got more members and more high cost claims happening there which is why we like to take a look at these things, normalized on a per patient or per thousand to try to do some plan comparisons.”
- President Breslin asked for clarification on the terms “employees” and “members”
- Ms. Coleridge also clarified that the term “members” are the total number of lives on the plans, and “employees” is defined as active employees, and early retirees.
- Plan performance is really done as an annual rating. And this looks at a ratio to average. Using the risk scores, we can see which plans are higher or lower than that, which ones are more efficient or less.
- We analyzed diabetes, hypertension, low-back pain, as well as readmissions. With readmissions we are really looking at admissions for the same patient within 15 days and your avoidable admissions. We are also looking at admissions that could have been preventable with other treatments.
- Commissioner Scott asked if we could review quality markers for readmission rates and avoidable admissions, so we could incorporate normative data into these analyses.
- Executive Director Yant confirmed that we will look at the normative data, and this example for readmissions was an example of improvement for the Health Plans working with HSS- we are below the average percentage of readmissions.
- Ms. Coleridge thanked Commissioner Scott and continued to discuss the patient complications analysis and how this database can sort through claims that denote a primary and secondary diagnosis.

(These next data points will cover members in the non-Medicare Population)

- The database tracks prevention care visits and screenings—mammograms were used as an example visit/screen that is being utilized by our members for prevention. These data tracking points are showing us that our members are using the prevention options because mammogram and colon cancer screenings had an uptick this year.
- The data system tracks top 10-episode groups. It is based on the most recent year statistics- HIV, diabetes, pregnancies—
- The Truven methodology allows us to break up the health episodes into pieces- chronic or non-chronic for example. The big cost drivers are in the chronic maintenance category
- Risk band profiles on the bottom left and these are based on your concurrent risk score. These risk bands, the way they get defined is Truven's market scan data base which has hundreds of millions of lives
- The data defined by risk scores can show us the lowest cost and have less to use in the system- this is about 72% of the total population- these members are either unhealthy or stable. Only a couple percent of the population drives the costs up.
- Reviewing the pharmaceutical drug costs both our therapeutic, by therapeutic class and then also the top 15 drugs. 14 of the 15 are specialty drugs. There is also a drug called Frazer that is driving up the costs of drug spending. Finally, there is a cost difference for generic and brand name prescriptions. On average an induvial on a plan may have 7 prescriptions a year.

This data pertains to the members in the Medicare population.

- Here there are two plans- Kaiser and United Health Medicare Advantage PPO.
- The Kaiser risk scores are significantly higher than those of the United Health Care populations. The utilization in terms of admissions and service is much higher with Kaiser versus United Health Care.

- HSS is waiting to get some more data on the prescription numbers from Kaiser. When they are available we will share.
- Metrics are less available on the Medicare side; however, we do have quality indicators in terms of readmissions and avoidable admissions. The Kaiser populations have higher rates in both categories.
- The prevention screenings are also up from last year- with cervical cancer screening, colon screening, cholesterol screening increasing.
- The top 10-episode groups in the Medicare population is diabetes. There are several cancers in here, HIV infections. As far as what's driving the acute conditions when we look at it by episode type its primarily joint disorders.
- A majority of this population is moving into higher risk categories- the risks are “struggling” and “in crisis.” Only 23.5% people that are either healthy or stable.
- Prescription drug numbers are not in yet; however, it is being hypothesized that the numbers are less than previous years.
- Commissioner Scott would like to see more normative data around readmission rates- quality check/assurance.
- President Breslin mentioned the screening rates, and the low numbers in all plans compared to Kaiser’s numbers.
- Ms. Coleridge responded that these numbers are based on our claim data, but she will double check the numbers because there could be some overlap from the members who moved to the MAPD plan.
- President Breslin commented on the cholesterol screening numbers verses the colon cancer screening.
- Ms., Coleridge agreed that the cholesterol screenings are considerably low with the Medicaid Advantage population. She noted that HSS will follow up with the data and she will also ask the United Health Care team to see if there is anything they missed, or if it is an outreach issue.

Public comments:

- Ms. Zvanski, RECCSF President, inquired on the increase numbers pertaining to Autism, and the ability to get member's children tested, as well as school placement options. She asked if the reclassification of the disorder will aid in the families getting more support with proper school placements.
- Ms. Zvanski also mentioned that there is little support and funding available in the school districts for screening, as well as certified professionals to complete the assessment.
- President Breslin asked for further public comment and asked that the next agenda item be called when no other person offered to make a comment.

Public Comment: none.

☐ 06142018-08 Discussion Item

Presentation of Healthcare Value Initiative (HVI) (Aon)

Documents provided to Board prior to meeting: Aon report.

Mike Clark presented the annual benchmarking – this study is something that Aon performed for over 20 years for our clients. It captures a robust cross section of employers across the United States almost 10.9 million health plan employees and dependents representing almost 500 employer organizations, $62 billion in healthcare expenditures.

- This data is for active employees only
- There are 5 different organizations we compared the SFHSS to—for comparative purposes. All the organizations are public sector, varying in size (all the organizations had over 25,000 plus employees)
- the San Francisco Health Service System pay an average of $12,578 per enrolled employee annually- SF HSS is paying 85.6% of that total healthcare dollar.
- There were tables presented sharing the payments for non-public and public

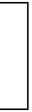
agencies to compare what the agencies pay versus the employee—

- Commissioner Scott asked about the bargaining agreements that public/city agencies must include when planning the benefits- there is less pressure in the non-public agencies comparisons since they do not use bargaining agreements
- Mr. Clark agreed that there is not an issue with the private agencies and bargaining agreements and directed the Board to compare SFHSS to the "public column of the report."
- Commissioner Scott asked for clarity on what "public entity meant"- city/county/state?
- Mr. Clark noted that this set is the collective of all public-sector employers who participate in our database. It does represent a blending of states, cities, and counties, municipalities.
- Commissioner Scott made a point that this report is presented every year, and the Board acknowledges that SFHSS pays more than other localities/entities—and he wondered what the value of this more specific/categorized report would be before the Board would make any further specialized requests for research.
- Mr. Clark shared that Aon has created a financial index that starts with the current employee costs and makes 3 adjustments to essentially normalize the population's characteristics to try to get it more of a comparative measure knowing that populations across plan sponsors are different. *The higher the index value the better this is, the greater purchasing efficiency you're receiving for the dollar*
- SF HSS has an index of 117.9% and this represents is our estimate that for every dollar SF HSS spends almost $1.18 of value of the dollar that you're spending in real terms is worth much more in terms of what the benefit is in return to the employees.

- We can normalize the ages of members, we can normalize differences for geographic cost factors, and we can also plan design variations for each organizations uniqueness.
- Commissioner Scott noted that the discussion is too broad, and he is concerned about the medical inflation costs that increase every year, so the fact that SFHSS spends more "dollars and we're doing it more efficiently, I don't know if that's a very persuasive business argument…"
- Executive Director Yant pointed out that this argument is beneficial to the employers who are negotiating their payments for the plans, so that when they are thinking about costs/inflation rates "we can possibly use that information in their negotiations."
- Mr. Clark mentioned that a majority of our employee healthcare spending is with Kaiser, with a small reduction from Kaiser to the SF City plan. Currently the City Plan represents about 3-4% of the dollars spent on active employees.
- President Breslin asked if the public group includes the Public Retirement System.
- Mr. Clark shared that Aon works with about 20-25 states and municipalities all over the country- there is a broad range of public sector organizations. CALPERS is not included in this range, and neither is Santa Clara County.
- Commissioner Scott asked if the data shared is just from the Aon client base.
- Mr. Clark confirmed that the data shared is out of the National Client Data base of public sector employees.
- Commissioner Lim pointed out that SFHSS spending on health care is in the middle of the 7 counties listed from the "Bay Area," and the comparison to the other jurisdictions out of California are not fair to the whole of the United States to our own system.

- Mr. Clark pointed to the fact that the number of employees in their data system from California approximately 436,000 and the totality in their database is about 5 million. So, to compare SFHSS cost, 15,177 per plan, to the overall labor market cost, 14,485, that on average Northern California has a higher cost than the U.S. average.
- Commissioner Lim mentioned that the “labor market” numbers are a combination of public and private employers, so this comparison does not reflect a national public sector with the public sector in California.
- Ms. Won Anderson (Aon) stated that this plan cost is just one of the many benchmarks Aon looks at throughout the year. She mentioned that this benchmark and the co-pay benchmark presented at an earlier meeting are mirroring each other in the cost analysis. This benchmark’s data is not “apples to apples.”
- Vice President Follansbee asked is there is an overlap in data between the labor market and the “10 county cost” that is conducted annually as a mandate from the state.
- Mr. Clark said that he would have to look through the data and get back to the Board.
- Vice President Follansbee then asked if the financial index formula is adapted from an industry formula or is it Aon’s own formula.
- Mr. Clark responded that this formula is a trademark tool and study that collects various data, Aon staff “plugs it into the program”, normalizes it and then compares it.
- The next page of the report shares three dependent coverage tiers- this is aggregated data across all SFHSS plans compared to the 5 databases. Then the next comparison is with employee plus one data and employee plus two or more data with the same methods mentioned above.
- The final page looks at the statistics from the 2018 year with the 5 comparators.

Public comments: None.



◻	Meeting Break		Recess from 2:18 to 2:32 PM
◻	08092018-09	Discussion item	Strategic Planning process update describing SF HSS Healthcare costs compared to industry benchmarks (Aon)

Documents provided to Board prior to meeting:

Aon Report.

Ms. Won Anderson from the Aon consultant group presented the Strategic Plan updates, specifically phase 2 of the plan, the benefit philosophy guiding principles section, and then next steps. We are moving from the “Discovery Phase” into the goals and objectives piece that encompasses designs and the solutions for the programs we work with.

- Meetings are being planned with Stakeholders, and from this feedback there will be a report out of the implementation plans, and a review process that will continue throughout the development of these plans.
- This whole process is occurring very quickly- it began in May and we will have a drafted Strategic Plan to present in the September Board meeting. Then the revisions and refinement will take place as the feedback is gathered.
- From the June meeting through today’s presentation we are asking you all to think about the overall health spectrum- thinking “about context setting and understanding the internal/external dynamics of health, what the problems are, what the challenges are, how we're seeing the workforce demographic change.”
- In July we meet with the HSS leadership for two days talking about goals and objectives.
- Vice President Follansbee asked if the two-day HSS leadership exercises included frontline staff as well.

- Ms. Anderson shared that the exercises in July constitutes HSS leadership members across the department's operational groups.
- Executive Director Yant conferred that the HSS management staff was included for the first meetings in July, however HSS management will include the frontline staff in the upcoming months, as well as the stakeholder meetings that will survey a broader member base in person.
- Vice President Follansbee noted that in HSS' staff survey there was an ask by the staff to be more engaged in this planning process.
- Ms. Anderson shared key roll ups from the June 22nd meeting: membership relevance, using our data to make informed decisions, as well as identifying the gaps in our current programs. Another area was HSS' engagement and collaboration internally and externally with members.
- Ms. Anderson also shared the need for HSS to focus on quality as a metric, and this will affect the change as it related to the affordability to cost. The fourth piece was figuring out a way to create a robust behavioral and mental health service plan.
- In July's meeting with leadership HSS' team built a good framework to build on, and core guiding principles to drive this forward.
- Those guiding principals were found during a group exercise the leadership team identified four categories: health and benefit strategy, insurance and care delivery, wellbeing, choice and guidance.
- The lenses on these categories are very different for actives versus early retirees versus Medicare whether you're a part of a labor group, departments, whether you have family units, job categories. The other lens is built around length of service alongside age/gender/income and ethnicity.
- We want to work with all levels and gather feedback continuously in the stages of this plan- having a short term, midterm and long-term planning in perspective. The strategy

as it is planned now is in a three-year strategy.

- Commissioner Scott pointed out that there was no mention of cost for these categories, and that the planning the work will be constrained by cost.
- Commissioner Scott reminded the Board that this plan must be mindful of the fiduciary reasonability to the members and the trust. He mentioned that we must show cost and quality go hand in hand, as well as the effectiveness of the care plan.
- Ms. Anderson shared the wellbeing plans with the Board and what that looks like in a broader definition. We care about the whole person.
- Another layer of the work focused on creating more tailored and individualized services without exclusivity.
- Further than service goals we also discussed opportunities to focus on the impact, quality and driving out current inefficiencies in the system.
- One of a more complex topic was the structure of health care and its lack of accessibility as the consumer. We considered options to incentivize the vendors to work on behalf and in good measure for HSS. This includes doing more work with our members in Health care literacy.
- We also discussed having more flexibility for program needs and member needs as their lives change. There was a lot of time brainstorming around services, programs, support tools in those areas.
- The next section of the work comes in as the mission, values, and vision. With each identified objective there is a business plan for each goal and specific tactics with a timeline.
- Commissioner Scott suggested that two members of the Board be invited to a planning meeting before the September presentation meeting.

- Executive Director Yant confirmed that she and President Breslin have discussed planning a meeting with one other Board member to gather their feedback and input. She also shared that there may be a need to have a special meeting to discuss this plan for additional people to weigh in.
- Ms. Anderson mentioned that in the appendix section of the plan there was a list of questions form the leadership meeting.
- Commissioner Scott shared his appreciation for this process and he is looking forward to the sharing of the planning updates in September.

Public comments: None.

☐ 08092018-10 Action Item

Appointment of Health Service Board Committee Chairs and Members for fiscal year 2018-2019

(President Breslin)

- Governance Committee
- Finance and Budget Committee

Documents provided to Board prior to meeting:

None.

President Breslin's job is to appointment members to the committees- she has made the following decisions for the chairs and members.

- Governance Committee will have Commissioner Scott as the Chair, and Commissioner Sharon Ferrigno and President Breslin as the members of the committee.
- Finance and Budget Committee will have Commissioner Wilfredo Lim as the Chair, and Vice President Follansbee as a member.
- Commissioner Lim asked how many members were on the Finance and Budget committee
- President Breslin confirmed that usually there are 3 members on the committee, however due to the shortage on the Board there will only be two members. A quorum is only 2 members for the committee.

- Commissioner Sharon Ferrigno motioned to approve President Breslin's committee recommendations.
- Commissioner Scott second
- President Breslin asked for all those in favor
- Commissioner Scott- Aye
  Commissioner Wilfredo Lim- Aye
  Commissioner Sharon Ferrigno- Aye
  Commissioner Rafael Mandelmen- Aye
  Vice President Stephen Follansbee-Aye

Public comments: none.

Action: Motion passed 6-0

☐ 08092018-11 Discussion Item

Report on network and health plan issues (if any)

(Respective plan representatives)

Public comments:

Ms. Denise Kruger- for active and retired fire fighters- asked a question about contract changes mid-year to the VSP benefits starting July 1. This change covered standard transition lens at no cost.

- This change is not fair to those who paid for lens out of pocket, and if this was meant to be a yearlong benefit it should reimburse those who paid.
- Executive Director Yant asked the representative from VSP to respond to this question.
- President Breslin believes that this is a temporary change.
- Ms. Nancy Jackson is the micro director from VSP. It was clarified that the new enhancement is not on transition lenses, it is for the lenses that turn into sunglasses when you are in the sun.
- AS of July 1, the lenses covered in full will be standard progressive lenses with a price of $50-55.
- The midyear change came into effect after some work had been done with a smaller set of fully insured clients, and July 1st we made this change effective as a global change. At VSP we wanted to improve the standard for all clients, and we wanted to provide more coverage for all members.

- Commissioner Scott asked about the reimbursement for those clients who already bought the lenses.
- Ms. Jackson believes that there is not much that she can do for those members who renew in January and have already bought these lenses, however she is going to check in with her internal team and get more information to share back with the HSS team.

Ms. Maureen O'Shea, retiree, discussed the rehabilitative nursing homes care coverage—she had issues with the United Health Care plan covering specific nursing homes being covered. (Jewish Home)

- Executive Director Yant asked the representative from United Health to respond to this question.
- Ms. Shannon Hass, United Healthcare, at this time there is an issue with Jewish Home being licensed as a skilled nursing facility. Currently there is a want to contract with Jewish Home if it is in fact a skilled nursing facility. This provider is also a willing provider for the United Healthcare Medicare Advantage PPO, and there are recent claims from this provider.
- Executive Director Yant shared that she has not had time to discuss the other two nursing home options with providers, but she will investigate it.
- Ms. O'Shea asked about the coverage for Jewish home by Medicare
- Ms. Hass explained that with the United Healthcare network a member has the same level of benefits out of network, so if you find an out of network provider who will use Medicare and accept United Healthcare their plan will work with that provider. If United Healthcare and the provider can work together on that is up to the provider's decision to take our member out of network.
- Commissioner Scott asked if at this time United Healthcare is working with Jewish Home in terms of possibly contracting.

- Ms. Hass shared that she is communicating with Jewish Home and they are open to contracting with United Healthcare. At this point the Jewish Home needs to make the decision if they want to or do not want a contract.

☐	08092018-12	Discussion Item	Opportunity to place items on future agendas Commissioner Scott would like to add a Formal thank you to Anthony Gan. Public comments: none
☐	08092018-13	Discussion Item	Opportunity for the public to comment on any matters within the Board's jurisdiction Public Comment: none

☐ Adjourn: 3:09pm

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

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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 Anthony Gan at (415) 554-0607 or email at anthony.gan@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) 554-0607