City & County of San Francisco
HEALTH SERVICE BOARD
1145 Market Street ✦ Suite 300 ✦ San Francisco, CA 94103

Minutes

Regular Meeting

Thursday, January 14, 2016

1:00 PM

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

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

President Randy Scott
Vice President Wilfredo Lim, excused
Commissioner Karen Breslin
Supervisor Mark Farrell, arrived 2:10 pm
Commissioner Sharon Ferrigno, arrived 1:27 pm
Commissioner Stephen Follansbee, M.D.
Commissioner Gregg Sass

This Health Service Board meeting was recorded 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.

- ☐ 01142016-01 Action item

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

- Regular meeting of December 10, 2015

Staff recommendation: Approve minutes.

Documents provided to Board prior to meeting: Draft minutes.

- Commissioner Breslin noted a correction under the section HSS Financial Reporting on page 15, sixth bullet in the first sentence.

The word “he” should be inserted after the word “that.”

- President Scott called attention to page 4 under public comment regarding parliamentary procedures and asked that the record show that the Board will follow the parliamentary guidance provided by the Board’s counsel. He thanked the member for her comment.

Public comments: None.

Action: Motion was moved and seconded by the Board to approve the regular meeting minutes of December 10, 2015, as edited.

Motion passed 4-0

□	01142016-02	Discussion item	General public comment on matters within the Board’s jurisdiction not appearing on today’s agenda

Public comments: None.

□	01142016-03	Discussion item	President’s Report (President Scott)

Documents provided to Board prior to meeting: None.

- President Scott noted that this meeting was the initiation of a new era in technological advancement for the Board with the introduction of iPads. Each Board member had been assigned an iPad that is the property of HSS. President Scott’s expectation was that the device would enhance the Board’s work and provide ready access to information previously paper-based.
- President Scott thanked Brian Rodriguez, HSS Information System specialist, who was in attendance to lend assistance to any Board member needing technical support with their iPad during the meeting. Mr. Rodriguez will attend the next few Board meetings to help with the new technology.
- President Scott also thanked Director Dodd for moving the Board into the 21st century.
- Director Dodd stated that in addition to improved access to meeting materials, the use of iPads will also provide savings on photocopying costs. She noted that the

packet of materials for this meeting comprised 154 pages. Those copies would have been in addition to the required 25 photocopied packets to be provided for the public.

Public comments: None.

□ 01142016-04 Discussion item Director's Report (Director Dodd)

- HSS Personnel
- Finance, Operations, Data Analytics, Communications, Wellness/EAP, Vendor Contracts
- Meetings with Key Departments
- Other additional updates

Documents provided to Board prior to meeting:

1. Director's report;
2. Reports from Operations, Data Analytics, Communications, Finance and Contracting, Wellness and Employee Assistance Program;
3. HSS engagement survey proposals;
4. Open Enrollment numbers;
5. Report on Minimal Essential Coverage ("MEC") for compliance with the Affordable Care Act notification (Mitchell Griggs).

- Director Dodd referenced her memo to the Board regarding the selection of an employee engagement survey for HSS staff participation. The Department of Public Health ("DPH") and the Department of Human Resources ("DHR") were contacted regarding each department's respective engagement surveys to determine whether either would be a viable tool to offer to HSS staff in terms of suitability and cost.
- DPH's engagement survey included information on patient experience and satisfaction. It was very expensive and did not fit the criteria for HSS.
- DHR has entered into a contract with Integral Talent Systems to design, develop and implement an employee engagement survey for CCSF. The scope of work consists of project planning and survey design, data

analysis and executive presentation, and an action plan with a 90-day follow-up with executive management (see memorandum).

- DHR's engagement survey better suits HSS' goals and objectives. The anticipated cost to initiate DHR's engagement survey is approximately $20,000, which is within HSS' budget. The initial survey could be conducted at HSS this year by reprioritizing work orders. It will be necessary to include the survey in the budget for next year.
- Director Dodd asked for the Board's approval to move forward with working with DHR on an employee engagement survey.
- Commissioner Follansbee stated that DHR's employee engagement survey appears to be a legitimate way to go. He asked if the survey questions would be generic across all departments or specific to HSS.
- Director Dodd stated that HSS would be able to insert specific questions into the survey. She noted that DHR's processing of employee issues is similar to those of HSS, which could be an advantage.
- Commissioner Breslin stated that since this matter would probably be taken up in the Governance Committee, DHR's engagement survey could be more thoroughly reviewed at that time. She stated her preference to see the survey questions before making a decision.
- In response to President Scott's inquiry, Deputy City Attorney Erik Rapoport stated that if a Request for Proposal ("RFP") were to be initiated, individual Board contact with a potential vendor would be prohibited prior to engagement of the process.
- Director Dodd requested that HSS be allowed to add onto DHR's engagement survey contract. DHR conducted the RFP process and Integral Talent Systems, Inc. was selected. There are funds available in DHR's work order budget for this fiscal year.

- Commissioner Breslin stated her concern regarding the Board having no prior knowledge of the questions to be asked on the survey, noting that this matter was originally brought up in the Governance Committee.
- President Scott stated that the Governance Committee instructed Director Dodd to look at engagement survey options but did not recall any discussion on reviewing the questions.
- Commissioner Breslin reiterated her request to review the survey questions.
- President Scott stated that the first step was to authorize Director Dodd to proceed with following up on DHR's engagement survey. Once engaged in the process, Director Dodd could report to the Governance Committee on her findings.
- Director Dodd suggested reviewing her memo summarizing the survey process and action plan, which she deemed more valuable because it held management accountable.
- Commissioner Follansbee stated that since the survey will be an annual occurrence, it was appropriate that the Board understand the scope of the survey prior to the rollout and what it would encompass to ensure it accomplishes what the Board thinks it should.
- Director Dodd compared the engagement survey to the wellbeing assessment, which cost hundreds of thousands of dollars. She noted that the Board reviewed the results but not the questions.
- President Scott instructed Director Dodd to proceed to work with DHR on its pilot engagement survey process. Once the survey document is near finalization, the Board would like to be notified through the Governance Committee.
- Regarding HSS Operations, Director Dodd reported an increase in last month's call volume due to the mailing of 63,000 open enrollment confirmation letters and ensuing questions or corrections.

- HSS also anticipates an increase in call volume regarding the ACA's requirement to offer minimal essential coverage, which is a legal regulatory requirement.
- Director Dodd called on Mitchell Griggs, HSS Deputy Director and COO, to explain the Affordable Care Act's ("ACA") employer reporting requirement of offering minimal essential coverage ("MEC").
- Mr. Griggs reported that the next compliance landmark for the ACA is an employer requirement confirming the offering of minimal essential coverage. He stated that HSS health plans provide minimal essential coverage.
- Employers are required to create two reports or forms to establish compliance with MEC:
    - 1094C includes submitting information to the IRS regarding the employer requirement to provide health coverage to full-time employees;
    - 1095C includes submitting information to all full-time employees for all four employers. This report will include retired and terminated individuals who received full or partial coverage during the year. The employee's copy will be furnished by March 31, 2016, which was expanded from original date of January 31, 2016.
- HSS will electronically file Forms 1094C and 1095C with the IRS by March 31, 2016.
- President Scott asked if the information being uploaded to the IRS on every member in the health plans is the value of the benefit.
- Mr. Griggs confirmed.
- He also stated that HMO members (Kaiser and Blue Shield) will receive a Form 1095B from their insurer, which will also list dependents.

- HSS will supply City Plan members with a form reporting health insurance coverage as the sponsor of the self-insured plan.
- Mr. Griggs stated that it took a huge effort to comply with the reporting requirements, including reviewing hundreds of IRS requirements (see report "Scope of Effort").
- Next steps include user acceptance testing, file testing with the IRS, generating a letter to members explaining the form and any action necessary, mail house testing and filing forms with the IRS.
- President Scott asked about the cost of the compliance effort.
- Mr. Griggs noted that the cost of postage has been identified but nothing else.
- President Scott asked for a rough estimate, stating that it would be informative for everyone.
- Mr. Griggs stated that he will also include the customer service aspect in his report on costs of compliance in March or April.
- Director Dodd stated that this process was started last April. While the IRS has extended its deadline for the reports to March 31, 2016, HSS intends to adhere to the original deadline of January 31, 2016. This is a testament to Mr. Griggs and the other HSS departments engaged in the process, which was a major undertaking.
- Dr. Follansbee asked if the 1095C would be available to members electronically. He also asked if the employee would need to include the 1095C with his or her income tax filing identical to the form electronically filed by the employer.
- Mr. Griggs confirmed that the Form 1095C received by the employee would need to accompany their tax return and W-2. However, the form would not be available electronically for the 2016 deadline.
- Director Dodd reported that approximately 2,500 members did not get loaded into Blue Shield's eligibility system, which increased the call volume into the 600s during the first

week of January. It was not merely an inconvenience; members were unable to access care. HSS met with Blue Shield yesterday and was assured that everyone has been entered.

- Director Dodd reported on the remainder of her Director's Report, which may be viewed on the myhss.org website.
- Commissioner Ferrigno arrived during this agenda item.

Public comments: Claire Zvanski, RECCSF representative, thanked HSS and Kaiser for this year's flu shot clinic at the RECCSF annual health fair. She also expressed appreciation for Margaret O'Sullivan's continued support and attendance at the retiree meetings. Ms. O'Sullivan has been making great strides with the retirees in terms of activity and wellness.

Ms. Zvanski expressed concern regarding the distribution of the Form 1094 for filing with the IRS since there was no mention of applicable forms for early retirees not receiving Medicare. She asked if other forms would be needed to fulfill the IRS' requirements for those members.

Mitchell Griggs clarified that the Form 1095C will be sent to all early retirees, including those with Medicare if they are City Plan members. Early retirees enrolled in Blue Shield or Kaiser will receive a Form 1095B from their HMO plan.

□ 01142016-05 Discussion item **HSS Financial Reporting as of November 30, 2015**
(Pamela Levin)

Documents provided to Board prior to meeting:

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

- Pamela Levin, HSS Deputy Director and CFO, provided a brief summary of revenues and expenses of the HSS Trust Fund and General Fund Administrative budget through November 30, 2015.
- The Trust Fund balance as of June 30, 2015 was $81.5M. The current fund balance

projection as of June 30, 2016 is $77M. The decrease of $4.5M in the fund balance was the result of several items such as pharmacy rebates, subsidizing rates and utilization. See financial update memo.

- The current projected balance for the Healthcare Sustainability Fund ($2.05), based on the current contribution models, is $42,000.
- The 2015 forfeiture amounts will not be available until after March due to the run-out period.
- The projected balance for the General Fund Administrative budget is $150,000 by year-end due to savings in salaries and non-personnel services.
- Commissioner Breslin asked for clarification regarding the forfeitures from the Flexible Spending Account ("FSA") being returned to the General Fund.
- Ms. Levin stated that all FSA forfeitures are deposited into the Trust Fund. Over the past few years, HSS used the forfeitures as revenue transferred to the General Fund when the costs associated with administration of the healthcare and dependent care FSAs exceeded the amount of revenues budgeted.
- Commissioner Breslin stated that she was still unclear about forfeitures transferred to the General Fund but did not want to hold up the meeting.
- President Scott stated that he did not understand the explanation and suggested that it might be useful at a future date to have a report on forfeitures and the General Fund.
- Commissioner Sass asked how the projection forecasts were determined on page 5 of the financial report. He specifically inquired about how City Plan's projected loss of $3.5M through November turned into a loss of $11.4M seven months later. In addition, Blue Shield's flex-fund had a $2.8M loss and projected a surplus at

the end of June. He questioned the loss in City Plan and how the loss in Blue Shield's flex-funded plan turned into a surplus.

- Ms. Levin stated that the City Plan projections were based on a straight line from the first x-number of months that were reported on. She stated that she would need to review Blue Shield's numbers and report back later.
- Commissioner Sass suggested that it would be helpful to see how the forecast is determined for each of the plans.

Public comments: None.

□ 01142016-06 Discussion item **Health Service System FY 2016-17 and FY 2017-18 Budget Instructions** (Pamela Levin)

Documents provided to Board prior to meeting: Budget memorandum.

- Pamela Levin reported on the budget instructions received from the Mayor's Office. For fiscal years 2016-17 and 2017-18. She stated that the final budget would be brought back to the Board for action on February 11, 2016. The budget will also include the 2-year budget for the Healthcare Sustainability Fund.
- The Mayor's Office, Controller's Office and the BOS Budget Analyst are projecting a general fund deficit of $99.8M in 2016-17 and a deficit of $140.4M in 2017-18.
- The projected deficit in the City's general fund is primarily due to increases in the employer retirement contributions to employee pensions and voter-approved propositions and set asides. See budget memo.
- Ms. Levin stated that the budget instructions are more complex this year. Not only is HSS required to submit a two-year budget, it may need to submit a fixed two-year budget. The fixed budget will not allow changes beyond existing administrative rules for transfers between expenditure categories and position

substitutions without the approval of the Board of Supervisors.

- President Scott expressed concern regarding the process and asked when the decision would be made on the departments selected for submitting a fixed budget.
- Ms. Levin stated that the issue will be heard by the Board of Supervisors' ("BOS") Budget and Finance Committee. Recommendations have been made by the Board's Budget Analyst.
- President Scott asked when the BOS Budget and Finance Committee meeting would take place, stating that the Health Service Board's Finance Committee should be engaged in the process and that the full Health Service Board should be informed. He also requested that the Board's Finance and Budget Committee meet prior to February 11, 2016 to walk through the budgeting process to ensure they understand and can inform the full Board on what needs to transpire.
- Ms. Levin stated that she would look for the date of the upcoming Board of Supervisors' meeting and will work with the Board Secretary to schedule a special Health Service Board Finance and Budget Committee meeting prior to the Board's regular meeting on February 11, 2016.
- President Scott reiterated his concern and asked Director Dodd and Ms. Levin how the Board may get engaged on the front-end and raise questions about the process, even though they may not be able to change the outcome.
- Director Dodd expressed appreciation for President Scott's support and stated that HSS will find out the date of the upcoming BOS Budget and Finance Committee meeting. She said that just making a 1.5% cut across the board is a challenge, especially with increased administrative costs due to the Affordable Care Act and the fact that HSS membership is over

approximately 113,000 lives. HSS' work is increasing not decreasing.

- Commissioner Sass noted that over 90% of HSS' revenue comes from work order recoveries from other departments and some of those departments are not subject to a freeze the second year. A significant amount of the revenue used to cover HSS' expenses in the administrative budget will be subject to changes that would influence its ability to balance the budget. He stated that unless all of those numbers work out favorably for HSS, compared to what was budgeted, HSS could be required to submit a supplemental appropriation. Through that process, HSS would be exposed to the Budget Analyst who is looking for other cuts and savings.
- Ms. Levin stated that the Mayor's Budget Analyst and Budget Director stated that once HSS' budget is established, they would adjust the other departments' budgets.
- The budget instructions require all departments to submit ongoing reductions in FY 2016-17 and FY 2017-18. HSS will be required to propose reductions and/or revenues equal to 1.5% of the General Fund support. These reductions will continue in the 2017-18 budget.
- The value of HSS' reduction in FY 2016-17 is $48,467. The reductions proposed in FY 2016-17 will remain in FY 2017-18 and an additional reduction of $48,467 must be proposed. HSS' budget must be submitted with these recommendations. The Mayor's Office stated that not all of HSS' recommendations will be accepted, therefore a balanced budget needs to be submitted.
- Director Dodd reminded the Board that once the Mayor's Office is finished with the HSS budget, the BOS Budget Analyst will propose further cuts.

Public comments: None.

□	01142016-07	Discussion item	Presentation of 2016 Rates and Benefits calendar for Plan Year 2017 (Director Dodd)

Documents provided to Board prior to meeting: 2016 Rates and Benefits meeting schedule for 2017 plan year.

- Director Dodd referenced the Rates and Benefits calendar stating that it was also subject to change.
- President Scott reminded everyone that the full Board acts as the Rates and Benefits Committee, which was eliminated last year in the governance process. He stated that it will be critically important for all Board members to attend the upcoming meetings to act on rates and benefits matters.

Public comments: None.

□	01142016-08	Discussion item	Educational presentation: Underwriting health insurance 101 (Aon Hewitt)

- Anil Kochhar, Aon Hewitt actuary, reported that Director Dodd asked him to provide a brief presentation on underwriting health insurance as the 2017 rates and benefits cycle begins.
- The purpose of underwriting is to rate the plan. It is a historical review of experience and projecting forward based on trend assumptions.
- The rate components are: paid claims, Incurred But Not Reported ("IBNR") reserve adjustment, trend, margin, administrative expenses and Affordable Care Act ("ACA") taxes and fees. See pages 3 and 4 of Aon Hewitt's report, "Underwriting Overview- The Science of Rate Setting."
- The components of healthcare trend are comprised several factors. As the population ages, more dollars are spent on medical services. See page 7 of report.
- Taxes and fees to be added to the rates are:
  - Patient Centered Outcomes Research Institute Fee (PCORI)
  - ACA Transitional Reinsurance Fee

    - Health Insurance Tax ("HIT")
    - Excise Tax (future)
- Since the Excise Tax originally scheduled for 2018 has been delayed to 2020, Aon Hewitt suggested not presenting its impact in this rates and benefits cycle. Aon Hewitt had previously presented several options and the Board considered a blending with the Flexible Spending Accounts ("FSAs").
- President Scott stated that the Board had taken an advanced review of the Excise Tax starting in 2014. While the implementation may be four years away, the Board still needs to be informed and consider how to move forward.
- Mr. Kochhar asked for permission to report on the status of the overall impact of the excise tax after the rate cycle has been completed rather than reviewing it each time a proposal is discussed.
- Commissioner Breslin asked whether multi-employer plans are entitled to use the family threshold for all participants for the excise tax. She referenced a November 2015 article on page 30 in the IFEBP Magazine, titled "What if ACA Excise Tax Isn't Repealed?"
- Mr. Kochhar stated that he would review the article and provide an answer after evaluation.
- Supervisor Farrell arrived during this agenda item.

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

Public comments: Claire Zvanski, RECCSF representative, stated that she had recently attended a town hall meeting with Assembly Member Ting, at which the subject of the Governor's tax for Medicaid was discussed. She asked where it would fit in the calculation of the rates.

Mr. Kochhar responded that state taxes are included but not itemized in the rate calculations. If the Managed Care Organization ("MCO") tax is approved, it will be added to the rates.

Director Dodd stated that she has alerted the BOS' legislative committee that the Governor has included the MCO tax proposal again. HSS is watching it but has not taken a position at this time.

Director Dodd also noted that a ballot proposition will be on the November ballot will fund Medi-Cal for hospitals. It is an extension of Prop 30, which is a tax on individuals who make more than $230,000 per year. It does not impact the MCO tax.

Pamela Levin asked to follow-up on agenda item 6 regarding the concern of HSS moving to a two-year fixed budget. She noted that it is at the call of the Chair of the BOS Budget and Finance Committee, which is Supervisor Farrell.

President Scott explained to Supervisor Farrell that the prospect of HSS moving to a fixed 2-year budget had caused him great concern. He stated his instructions to the Health Service Board Finance Committee to work with Ms. Levin and Director Dodd to ensure that there is a complete dialog regarding the process and the implications to HSS.

Supervisor Farrell stated that it was unclear whether those items would be heard by the BOS. The question was whether it was a better use of time from a strategic planning perspective not to have CFOs and department heads come before the Board of Supervisors in what amounts to an arbitrary process and that staff time might be better spent addressing future planning roles within an organization. There had been no conclusion to the discussion. He questioned whether it made sense for from a staff perspective to have departments go through the budget process each year at the Board of Supervisors where potentially under 1% of the budget will be moved. Some departments would be better served by having staff perform other duties.

□	01142016-09	Discussion item	Health Plans' Dashboard through Q2 2015 (Aon Hewitt and HSS)

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

- Marina Coleridge, HSS Data Analytics Manager and Paige Sipes-Metzler, Aon Hewitt presented this agenda item.

- Ms. Coleridge reported that HSS has been involved in a multi-year initiative to enhance dashboard reporting. The goal was to improve data collection standards, make the dashboard more flexible, informative, and incorporate benchmarks.
- The All-Payer Claims Database ("APCD") is a tool to inform policymaking, benefit design, and obtain comparable information on the cost effectiveness and performance of the health plans' healthcare delivery.
- The APCD was released into production in Q4 of 2014 and is hosted by Truven Health Analytics.
- Alisa Sanchez, Truven Account Director, was in attendance to answer any questions specifically regarding the APCD, if necessary.
- Ms. Coleridge stated that it had been a Herculean effort in launching the APCD, which involved the partnership of all HSS health plans. She thanked all of the health plans and Truven in assisting in the work.
- Ms. Coleridge specifically recognized Sharmini Bhatnagar, Senior Health Program Planner and member of the Data Analytics team, for singly conducting the vast majority of the detailed analysis.
- Ms. Coleridge outlined some of the steps in the data collection the process, which was quite an intensive undertaking.
- The APCD report presented to the Board completed the first phase in transitioning the evaluation of the health plans' performance from the vendor to the APCD. The report detailed inpatient, outpatient and pharmacy utilization and trends across Blue Shield, Kaiser Permanente and City Plan for the active population through Q-2 2015. Since this was the first integrative dashboard, those comparisons were performed on an aggregate total level. The comparisons were not risk-adjusted values; however, the next maintenance update of the APCD will include risk scores calculations.

- The data in this report was sourced from the vendors and the transition is ongoing. Blue Shield's cost measures were sourced from vendor reports because the financials were not provided at the detail claim level in the APCD.
- The APCD underwent a vigorous data investigation and the threshold was less than a 3% variance.
- Director Dodd asked whether the lack of claims data from Sutter made a difference in the accuracy of the APCD.
- Ms. Coleridge responded that the vendor reports from Blue shield were used for some data but that it did undermine the APCD. The information is included in utilization but not in the financials.
- Paige Sipes-Metzler, Aon Hewitt, reported on demographics.
- 43,401 Members were enrolled in Kaiser as of the second quarter of 2015. Twenty-five percent (25%) of those members are under the age of 20 and 35% are in the age range of 45 to 64.
- 32,588 Members were enrolled in Blue Shield as of the second quarter of 2015. Twenty-four percent (24%) of those members are under the age of 20 and 41% are in the age range of 45 to 64.
- The goal over the past few years had been to move more families back to Blue Shield from Kaiser. While 124 families moved from Kaiser to Blue Shield, it made no difference in the overall population distribution within Blue Shield.
- City Plan currently has only 876 members. Due to the small numbers, every admission in City Plan has an impact worth 14% more than Kaiser (which is 2.2% of the whole) and Blue Shield (3% of the whole).
- Fifty-five percent (55%) of City Plan members are in the age range of 45 to 64. This may indicate that City Plan members are seeking physicians and care that may not be

available through either Blue Shield or Kaiser.

- City Plan continues to be the most expensive plan at $1,348 per member per month ("PMPM"). This is a change of 44% in the two-year period being reviewed. City Plan's membership has dropped by 200, which means each member has a greater influence on the costs of the plan.
- Blue Shield's PMPM cost is $560. Its costs have increased by approximately 16%.
- Kaiser Permanente's PMPM cost is $415. Its costs have increased by only 6.5%.
- Kaiser Permanente's and Blue Shield's pharmacy costs have increased by 17% and 18% respectively.
- Ms. Sipes-Metzler noted that the average length of hospital stay for City Plan and Blue Shield is a half day more than Kaiser Permanente. Each half day represents nearly $4,000. While Kaiser's per day hospital cost is higher, it has fewer admissions and the length of stay is controlled making its costs within reason.
- Pharmacy costs are trending up significantly.
    - Kaiser's pharmacy cost is $51 PMPM.
    - Blue Shield's pharmacy cost is $91 PMPM.
    - City Plan's pharmacy cost is $267 PMPM.
- Blue Shield and City Plan should be commended for reducing the average length of hospital stay by a whole day during the two-year period under review.
- Aon Hewitt recommended that the Board encourage Blue Shield to reduce the ongoing gap with Kaiser Permanente by 10% to reduce the 7-day gap in the admits.
- Ms. Coleridge reported that next steps would include the calculation of risk scores in the next update.

- Ms. Coleridge reported that HSS has begun analytical validation of the data for the early retiree population. The information will be provided in integrated dashboards on an ongoing basis.
- President Scott commended Ms. Coleridge and her staff for such a Herculean effort. He expressed the hope that based on the information provided, the Board will have a more informed understanding as the actuaries present the rates and trends.
- Commissioner Follansbee asked if hospital days in the 45 to 64 age group could be a part of the risk adjustment since there is a big difference between Kaiser and Blue Shield (35% versus 41%).
- Commissioner Follansbee also asked if new members were enrolling in City Plan.
- Ms. Sipes-Metzler stated that City Plan provides coverage for other service areas such as Hetch Hetchy. She noted that there has not been much growth in City Plan. The younger population has not enrolled in City Plan to offset the middle age population with chronic illnesses.
- Commissioner Sass asked why Blue Shield's flex-funded plan has exceeded HSS' projections. Losses have been incurred causing larger amounts to be transferred from the trust fund each year to pay the costs of this plan. He stated that it appears that the price of service is the factor that was leading to large increases.

Public comments: None.

□	Meting Break		Recess from 3:07 to 3:15 pm
□	01142016-10	Discussion item	Presentation of possible new health plan option: Sutter (Sutter Health Representative) Staff recommendation: Direct HSS staff to pursue rate calculations for consideration for 2017 plan year.

- Rob Carnaroli, Vice President, Sutter Health Plus, thanked the Board for the opportunity to introduce his organization to CCSF as one

of the newest health plans in Northern California.

- Steve Nolte, Sutter Health Plus Chief Executive Officer, was also in attendance. Mr. Nolte has been with Sutter Health Plus since its inception and has been instrumental in the build, expansion and day-to-day operations in the Sacramento facility.
- Sutter Health Plus has been in Northern California for over 100 years. It is a recognized and respected brand in the community with California Pacific Medical Center in San Francisco and Alta Bates across the Bay.
- Sutter Health Plus recognized, in this post-ACA environment, the need to bring quality and affordability in its health plan and believe they can bring quality and affordability to various employers throughout Northern California.
- Sutter Health Plus filed for its Knox-Keene license in 2013. By January 1, 2014, it was up and running with the first member through the County of Sacramento. It expanded to Sonoma County in March 2015 because a new hospital had just been built in the heart of Santa Rosa along the 101 corridor.
- In October 2015, Sutter Health Plus received Department approval to expand into San Francisco, Alameda, Contra Costa, San Mateo and parts of Santa Clara County. It has currently 16 hospitals and 3,600 providers in the Bay Area. See pages 3 and 4 for the list of Bay Area and Valley networks and physician organizations.
- After two years, the plan has grown to over 35,000 members of which 66% are new to Sutter Health.
- Mr. Carnaroli formally requested that the Board allow Sutter Health Plus to work with Aon Hewitt to pursue rates and benefits for the City and County of San Francisco.

- Commissioner Follansbee asked how "new" was defined regarding the 66% new members in Sutter Health Plus.
- Mr. Carnaroli responded that someone who had not used the Sutter system for the previous two years prior to enrolling with Sutter Health Plus was considered "new."
- Commissioner Follansbee stated that many of Sutter Health's physician organizations are actually Sutter foundation physicians. He asked if it is a health plan that is contracting with Sutter hospitals and Sutter foundation physicians.
- Mr. Carnaroli replied affirmatively.
- Director Dodd stated that when Sutter Health had expanded into Sonoma, HSS had received complaints from members that they were no longer able to see their regular doctor and had to switch to a Sutter physician. This can be very disruptive, especially for retirees who have a long history with their doctor. She asked if any thought was given to how people would react.
- Mr. Carnaroli stated that he was unaware of the details of the Sonoma situation but would look into it.
- Commissioner Breslin asked why Sutter Health Plus would be more affordable than the other health plans.
- Mr. Carnaroli stated that Sutter Health Plus brings the same components as an ACO with shared governance, shared decision-making and shared financial responsibility.
- Commissioner Ferrigno asked if Novato Community Hospital is in the Sutter network.
- Mr. Carnaroli stated that Novato Community Hospital is in Sutter's network; however, Sutter Health Plus does not have physicians in Marin County. Sonoma physicians can refer to Novato. For those living in the southern part of Marin County, Sutter Pacific Medical Foundation can admit to Novato.
- Director Dodd stated that HSS obtains data from Kaiser Permanente, which is a fully integrated system. She asked if the Board

decides to proceed with Sutter Health Plus, can HSS count on getting the data feeds necessary to look at quality and cost across vendors.

- Mr. Carnaroli deferred to Steve Nolte, Sutter Health Plus Chief Executive Officer, to answer the question.
- Mr. Nolte responded affirmatively stating that Sutter Health Plus has a shared responsibility to change the way people perceive healthcare.
- Commissioner Follansbee asked if Sutter Health Plus is a non-profit health plan.
- Mr. Nolte confirmed.
- Commissioner Sass asked with 35,000 members at what point is the membership significantly large enough for Sutter Health Plus to make a valid statistical forecast about the cost of healthcare and what might impact the cost of service.
- Mr. Nolte stated that Sutter Health Plus is a solely sponsored health plan, which means that unlike most payer organizations, it does not have a third party in the process.

Documents provided to Board prior to meeting: Sutter Health Plan handout.

Public comments: Claire Zvanski, RECCSF representative, stated that she found it very interesting that there was no mention of early retirees and whether there was any opportunity for Medicare or MAPD plans. It is a very a narrow network. Her friends in Tuolumne County would be very disappointed that that area was not included. She suggested considering making changes to the plan that can serve HSS' full membership, including the Tuolumne employees. She asked if Sutter has been deliberately maintaining very high costs compared to other plans in order to come in and lowball the market with its own plan. Otherwise she would expect that they would make the same offerings through Blue Shield and UnitedHealthcare so that they can continue to participate in the market. Otherwise she views adding Sutter Health Plus network as very divisive.

Ms. Zvanski also stated her belief that the process requires a Request for Proposal ("RFP") to consider adding any other plan to the network. The full membership, including retirees, should be considered.

Emma Erbach, IFPTE Local 21 representative, stated that they are seeing more members moving out of the County, making it very important to review this potential healthcare plan very carefully. She echoed Ms. Zvanski's comments regarding the current exceedingly high costs of Sutter healthcare and whether the promises rang true that suddenly costs would drop. She referenced a December 2013 article in the New York Times regarding hospitals and serious overcharges to patients (i.e., one stitch cost upwards of $500). She asked the Board to carefully review Sutter's information around affordability as she would loathe the implementation of a new plan that starts low and dramatically increases. She mentioned the UFCW lawsuit against Sutter regarding transparency in its pricing and hoped that it would be taken into consideration by the Board before agreeing to add a new healthcare plan with a corporation that has long had allegations against it for the lack of transparency and price gouging.

Dennis Kruger, active and retired firefighters' representative, reminded the Board of last year's near disruption of service by Blue Shield due to a breakdown in contract negotiations with Sutter. Members were notified of potentially losing their doctors if an agreement could not be reached. He suggested locking Sutter into a multi-year agreement if the Board decides to add it to the network. His fear is that should Sutter be added, once in, it will change the order in which they do business. Based on its past history with Sutter, he asked the Board to carefully consider everything mentioned when reviewing its system. He is looking forward to the rates and benefits process to get better insight into Sutter's proposals.

President Scott stated that on behalf of the Board he requested that Director Dodd undertake consideration of Sutter Health Plus as part of the rates and benefits process.

Supervisor Farrell stated that he agreed with Ms. Zvanski's comments and expressed concern. He hoped that the questions could be explored in the process.

□	01142016-11	Discussion and possible action item	Cal INDEX Blue Shield database follow-up discussion from December 10, 2015 Health Service Board meeting (Cal INDEX/Blue Shield Representative)

Documents provided to Board prior to meeting: Follow-up report prepared by Cal INDEX.

- Simon Jones, Vice President, HIT Product Strategy, with Blue Shield of California stated that Andrea Leeb, Chief Privacy officer of Cal INDEX had joined him to address the Board. He noted that Jen Pacheco, Cal INDEX Director of Strategic Accounts, was also in the audience.
- Mr. Jones stated that Cal INDEX did not convey its benefits to the members very well at the last meeting. He provided an anecdote about his son who is severely autistic, non-verbal and on a slate of medications and how information in the Cal INDEX database could make a difference in his treatment if a trip to the emergency department were necessary and neither of his parents were present.
- Cal INDEX is attempting to leverage the technology to bring information together in a digital infrastructure that has not been in place previously. Its mission is not for Blue Shield members only but all Californians.
- Cal INDEX is an integrated data exchange representing the State of California. It is a not-for-profit mutual benefit corporation controlled by its Board of Directors.
- Financial data is not contained in Cal INDEX. It is not a tool for any provider or payer organization to leverage a competitive scenario. The intent of Cal INDEX is to provide higher quality care not create a strategic advantage for any given party.
- Research criteria is codified very carefully and because Cal INDEX was concerned about the information being used for unintended purposes, such as those discussed with

Commissioner Follansbee at the previous meeting. The intent was to create a database that would be accessible to researchers to assist in their analyses.

- Cal INDEX was launched in August 2014 and became an official organization in September 2014.
- Commissioner Follansbee asked why anyone could not request their record directly from Cal INDEX rather than through their health plan.
- Andrea Leeb, Cal INDEX Chief Privacy Officer, responded that under HIPAA, Blue Shield providers are covered entities and have the first relationship with the consumer, not Cal INDEX. In the future, there may be a way to authenticate people to allow receiving information directly from Cal INDEX but such a system is not currently in place.
- Commissioner Follansbee stated that he had been involved in databases previously regarding HIV and it was very difficult to get physicians or staff to find time to fill out a minimal database with a chart that would be useful in a large database. He asked if physicians or their offices are reimbursed for the time spent submitting the information to patients who ask for it (as well reimbursement for the time spent, costs of the paper and staff time).
- Ms. Leeb stated that physicians are not reimbursed for their time, staff's time or supplies.
- Director Dodd asked if patients would be able to change their information in Cal INDEX if it is incorrect.
- Ms. Leeb stated that under HIPAA, patients may ask for an amendment to their data through their provider.
- Director Dodd asked about funding for Cal INDEX since it was previously acknowledged that data will be used for research. She asked for assurance that in a few years, members' data is not sold to another organization since there is no agreement

between HSS and Cal INDEX that protects members from having their data sold in ten years.

- Ms. Leeb stated that patients' data cannot be sold legally. The law only allows Cal INDEX to use patient data to the extent permitted by the contract.
- Director Dodd asked if researchers will have access to the data.
- Ms. Leeb responded that researchers will not have direct access to the data; they would need to first submit a research proposal. To date, they have not engaged in any research activities. Cal INDEX will create and work with an IRB to review the research proposal with its Board and make a decision on whether to participate in the research.
- Director Dodd stated that it was previously reported that even if members opt out, their data is still in the exchange being transmitted. She asked if Cal INDEX could potential use the data.
- Ms. Leeb stated that Cal INDEX is prohibited from using the data. It is completely blocked as set forth in its privacy practices as well as its contract.
- President Scott stated that he still had a fundamental concern regarding how the data exchange was rolled out. Even though members can opt out, each individual must make the effort to contact Cal INDEX to make their choice known. He voiced his dismay at making members opt out of something that they had no knowledge of being opted into.
- Director Dodd stated that she had a chronology of the communications between Blue Shield and HSS. The first letter was sent out by Blue Shield in October 2014. HSS was stunned but were told they could not change it and it was not HSS' data to hold back. She then requested that the letter not go out in the middle of an election cycle during the height of junk mail being sent out. HSS was notified twice in March and again in September and October of

2015. However, none of the letters were approved by HSS.

Public comments: Claire Zvanski, RECCSF representative, stated that she supported President Scott's comments and expressed great concern for members who are unaware that their data is being collected and used and were not properly informed. She stated that she will relay the information that was reported in this meeting and the last to the retiree community. While it is good to have shared medical data, and knows that many members who belong to Kaiser appreciate that system, this was implemented without member consent. She stated that this was very problematic. While the concept is fine the process of how it was done, the issues with HSS not vetting any of the letters and not allowing members the opportunity to opt into the program is very problematic. She expressed hope that something could be done in the future. Members needed to be informed that their data was being utilized and despite the protections of HIPAA, she had very serious concerns.

Emma Erbach, Local 21 representative echoed the comments of Ms. Zvanski. She expressed concern that members were unaware of their data being shared or how it would be used. She stated that while the privacy notice is useful, asking members to opt out rather than asking them to opt in was very disingenuous. She encouraged HSS to consider sending out letters to members to opt out with the understanding that after they research it, they can opt back in. Members will then be making an informed choice and not simply be lumped into a group without any knowledge of what it means.

Dennis Kruger, active and retired firefighters' representative, stated that as one of the people who opted out last year when he received the letter, it was not disclosed that his information would remain in the database and that it could be accessed internally even though assurances have been made that Cal INDEX will not do so. He proposed that the information be deleted when members opt out. Otherwise why opt out?

Commissioner Follansbee stated support for the universal medical record. He heard the assurances about privacy and appreciated that there would be no research if there was no IRB. However, he was

still bothered by the process. He had been involved in other opt out processes as a physician and he stated that even physicians do not understand how to opt out of things. He recommended that HSS staff consider drafting a letter to all Blue Shield members that this is an issue and to look at the program.

President Scott asked if there was Board consent regarding directing a letter be drafted by the HSS Executive Director for review by the Board regarding the Cal INDEX program which would be sent to Blue Shield members who are a part of HSS.

Upon hearing no objection, President Scott moved to proceed and once the letter is drafted the Board will review it.

Commissioner Breslin seconded the motion.

Commissioner Sass also suggested including this item in the regular HSS newsletters and any other appropriate member communications.

Director Dodd asked how Cal INDEX would handle a child with developmental disabilities who has been enrolled in a regional center or received state services and whether his or her data would in the longitudinal records so that an emergency department would know the medications being taken.

Ms. Leeb responded that the privacy exclusions require specific consent under the law, such as "I will allow Dr. Smith to see my records." Therefore a longitudinal patient record set could not be created.

President Scott stated that Blue Shield should also pay for the cost of the mailing once it is drafted.

Action: Motion was moved and seconded by the Board to direct the HSS Executive Director to draft a letter for the Board's review notifying HSS Blue Shield members of their right to opt out of Cal INDEX, which will be sent via U.S. mail paid for by Blue Shield and electronic mail.

Motion passed 6-0.

After the above discussion, President Scott stated that due to a member appeal via telephone conference, the remaining agenda items would be suspended to hold a closed session.

			Commissioner Follansbee moved to suspend the remainder of the meeting to hold a closed session. Commissioner Breslin seconded it. Action: Motion was moved and seconded to suspend the meeting. Motion passed 6-0.
□	01142016-12	Discussion and possible action item	Educational presentation: Surrogacy Coverage (Aon Hewitt) Documents provided to Board prior to meeting: White paper prepared by Aon Hewitt Public comments: Action: No action taken. Continued to next meeting.
□	01142016-13	Action Item	Health Service System 2015 Annual Report Documents provided to Board prior to meeting: 2015 Annual Report Public comments: Action: No action taken. Continued to next meeting.
□	01142016-14	Discussion item	Report on network and health plan issues (if any) (Respective plan representatives) Public comments: None.
□	01142016-15	Discussion item	Opportunity to place items on future agendas Public comments: None.
□	01142016-16	Discussion item	Opportunity for the public to comment on any matters within the Board's jurisdiction Public comments: None.
□	01142016-17	Action Item	Vote on whether to hold closed session for member appeal (President Scott) Staff recommendation: Hold closed session. Public comment on all matters pertaining to the closed session. Action:

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.

□ 01142016-18 Action Item

Member appeal (President Scott)

Documents provided to Board prior to meeting:

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

Staff recommendation: Uphold HSS decision.

Reconvene in Open Session

□ 01142016-19 Action item

Possible report on action taken in closed session regarding member appeal (Government Code Section 54957.1(a)(5) and San Francisco Administrative Code Section 67.12) (President Scott)

Public Comments: None.

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

Motion passed 5-0.

□ 01142016-20 Action item

Vote to elect whether to disclose any or all discussion held in Closed Session (San Francisco Administrative Code Section 67.12) (President Scott)

Public Comments: None.

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

Motion passed 5-0.

□ Adjourn: 5:19 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.

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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