HEALTH SERVICE BOARD
CITY & COUNTY OF SAN FRANCISCO

# Minutes

## Special Meeting

Tuesday, June 21, 2016

12:00 PM

1145 Market Street, 6th Floor
(Retirement System Hearing Room)
San Francisco, California 94103

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

President Randy Scott
Vice President Wilfredo Lim
Commissioner Karen Breslin
Supervisor Mark Farrell, arrived 12:09 pm
Commissioner Sharon Ferrigno, arrived 12:16 pm
Commissioner Stephen Follansbee, M.D., excused
Commissioner Gregg Sass

This special meeting was called to order at 12:04 pm. President Scott thanked the San Francisco Employees' Retirement System Director, Jay Huish, for allowing the Health Service Board to utilize their Hearing Room due to room unavailability at City Hall. He also expressed appreciation to the SFERS' staff for assistance with this special meeting.

President Scott announced that all agenda items would be called at one time to allow discussion of each item before taking a final vote.

President Scott called for items 1, 2, 4 and 5 to be read first, followed by item 3. He instructed the actuary to concentrate on major points and critical issues in each presentation.

This meeting addressed the rates and benefits for HSS' non-Kaiser Medicare retired members for the 2017 plan year currently covered by Blue Shield and UnitedHealthcare.

## RATES AND BENEFITS

| | | | |
|---|---|---|---|
| □ | 06212016-01 | Discussion and possible action item | Approve Blue Shield Medicare Advantage fully-funded retiree rates and premium contributions for 2017 plan year (Aon Hewitt) |

Documents provided to Board prior to meeting: Report prepared by Aon Hewitt, "Blue Shield Medicare Advantage fully-funded retiree rates and premium contributions for the 2017 plan year."

- Anil Kochhar, Aon Hewitt actuary, stated that of the approximately 114,000 HSS members, nearly 37,000 are retirees.
- Blue Shield's current retiree enrollment comprises approximately 6,000 members under two programs, BSC 65-Plus (MAPD) and BSC Access+ (COB).
- For the 2017 plan year, Blue Shield proposed an increase of 10.2% over the 2016 rates or $406.17 per retiree per month.
- Blue Shield also adopted a Medicare Premium Employer Group Waiver Plan "(EGWP") Formulary for the 2017 plan year for prescription drugs. This Medicare premium formulary is similar to UHC's PPO formulary adopted by the Board in 2015.
- Mr. Kochhar noted that the change in formulary will alter the current copay structure of $10-$25-$50 and increase some members' pharmacy copays (i.e., from $25 to $50 in some instances). This increase will affect 2,228 of Blue Shield's members (or 32%) resulting in higher copays.
- See pages 3 and 4 of Aon report.
- At President Scott's request, Dr. Paige Sipes-Metzler, Aon representative, presented highlights of the Medicare Premium EGWP formulary.
- There are currently five tiers in Blue Shield's 2016 EGWP formulary.

- Blue Shield's 2017 Medicare Premium EGWP formulary will have six tiers: two-tiered generics; two-tiered brands and two-tiered specialty drugs.
- There are 214 drugs in the 2017 Medicare Premium EGWP formulary that will have higher copays. Of those medications, 16 are chronic care drugs which copays will increase from $20 to $100.
- See Appendix 3 of Aon's report for Blue Shield's 2017 Medicare Part D formulary evaluation and costs.
- See page 9 for Blue Shield's 2017 65-Plus/BSC Access+ (COB) monthly rate card with revised Medicare premium EGWP formulary.
- A comparison of Blue Shield's 2016 and 2017 costs in the revised Medicare Premium EGWP formulary may be found on page 10 of Aon's report.
- Mr. Kochhar stated that Blue Shield's 2017 Medicare Advantage fully-funded renewal was status quo with the exception of the formulary change.
- Supervisor Farrell asked if this renewal was a dramatic increase.
- Mr. Kochhar responded affirmatively and stated that Blue Shield's double-digit increase was higher than the other Medicare Advantage programs.
- President Scott asked if Blue Shield seemed to be inclined to make adjustments to its rates this year.
- Mr. Kochhar responded that the current proposal was Blue Shield's adjusted best and final offer for the 2017 plan year.
- Commissioner Breslin asked if the cost of Blue Shield's EGWP was known.
- Mr. Kochhar stated that he did not know what Blue Shield pays for its EGWP product.

- Aon recommended that if the Health Service Board did not adopt the plan to fully fund the current City Plan PPO and offer the UHC Medicare Advantage PPO "New Fully-Funded City Plan" as a substitute to Blue Shield of California, the Board should adopt the BSC 65-Plus (MAPD)/BSC Access+ (COB) renewal with the revised BSC Medicare Premium EGWP formulary.

Public comments: Herbert Weiner, retired City employee, asked why Blue Shield was not transparent about its EGWP costs. He stated that he could not accept Blue Shield's proposed EGWP costs since they were undocumented, and noted that Blue Shield had a responsibility to disclose the information.

Claire Zvanski, RECCSF representative, expressed disappointment in Blue Shield's proposed 2017 renewal of 10.2% and stated that it was unjustified. The increased copays for 214 drugs from $20 to $100 was especially distressing, considering that many retirees are on fixed incomes. Such an increase would render a significant number of drugs as unaffordable for retired members. She stated her belief that Blue Shield's underwriters excessively rate their costs and that increases at a phenomenal percentage are unsustainable for retirees.

Dennis Kruger, representative for active, retired and widowed firefighters, asked if the Board rejected the proposed 2017 Medicare renewal, would Blue Shield's plan as a whole for CCSF be rejected. He also asked whether the consideration of a retiree plan (separate from actives) was an exception to the usual process. He thought a complete plan covered all members, actives and retirees.

Director Dodd stated that in her seven (7) years of experience at HSS, rates for actives and early retirees had been voted on separately from Medicare retirees.

Fred Sanchez, member of Protect Our Benefits, stated that 10.2% was a tremendous increase. He urged the Board to delay its vote because there was not enough information to make a decision. He stated that with retirees receiving a 2% COLA, Blue Shield's proposed increase was massive and

unaffordable. He also asked for more transparency from Blue Shield.

Action: None.

| | | | |
|---|---|---|---|
| □ | 06212016-02 | Discussion and possible action item | Approve UHC Medicare Advantage PPO fully-funded retiree rates and premium contributions for 2017 plan year (Aon Hewitt) |

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

- Anil Kochhar reported on UHC's 2017 fully-funded Medicare Advantage PPO plan.
- As of May 1, 2016, enrollment in UHC's Medicare Advantage PPO plan was 1,345 retirees with dependents.
- UHC proposed an increase of 9.5% for 2017 or $334.11 per retiree per month.
- See page 4 of Aon's report for UHC's 2017 Medicare Advantage PPO monthly rate card. With the addition of vision, the healthcare sustainability fee and Best Doctors' fee, the monthly retiree rate is $342.46.
- Page 5 of Aon's report compares UHC's 2016 and 2017 Medicare Advantage PPO retiree renewal premiums and contributions.
- Commissioner Breslin asked how many retirees from the City Plan enrolled in UHC's Medicare Advantage PPO plan.
- Mr. Kochhar responded that as of May, 1 2016, approximately 600 retirees left City Plan and 600 retirees left Blue Shield to join UHC's Medicare Advantage PPO plan.
- Commissioner Breslin also asked for confirmation of member satisfaction, since it had been reported that there were no member complaints regarding unresolved issues.
- Director Dodd stated that there had been a handful of member complaints but all had been resolved satisfactorily.

- Commissioner Breslin inquired about the 9.5% increase of this plan. Since this plan is in the honeymoon stage, she considered the proposed increase substantial.
- Director Dodd stated that the majority of the plan's increase was due to CMS' increase to the EGWP fees. She reminded everyone of the extensive discussion at the May Board meeting regarding this matter.
- Ward Brigham, UnitedHealthcare representative, reported that the 9.5% increase was driven by approximately 4% on the medical trend and the remaining on the EGWP trend associated with CMS' reinsurance changes.

Public comments: Claire Zvanski, RECCSF representative, expressed confusion on the explanation of the plan's increase due to EGWP because she thought it applied only to early retirees.

Mr. Kochhar clarified that EGWP is a CMS program specific to post-65 Medicare retirees.

Sharon Johnson, Protect Our Benefits member, asked if there was a dire need to have this item heard and finished at this meeting in order to present to the Board of Supervisors. She asked if a public hearing could be scheduled to consider the change and move forward at a later time. She also stated that she was a long time City Plan member. When she asked her doctor about City Plan and the new healthcare PPO introduced last year, her doctor advised her to remain in City Plan because it was the best plan available.

Maureen O'Shea, retired City employee, requested that this matter be continued unless there was a pressing reason to hold a vote at this meeting. She only heard of this matter through the grapevine a couple of days prior and surmised that other retirees would like an opportunity to attend a meeting on the subject and comment. She was satisfied with her current health plan and asked that a great deal of consideration be given before the plans are changed or this option is taken away.

President Scott reminded the audience of the sequence of topics, noting that Item 2 was the current discussion. He asked members to restrict

comments to the current item and wait until item 5 was presented before weighing in on that matter. He acknowledged the many emails, letters and phone calls regarding item 5 but stated that all items would be taken in turn.

Claire Zvanski asked why the family rate was higher in this PPO plan than the Blue Shield option--$1,030 versus $825.

Mr. Kochhar responded that the Medicare portion of the rates included the cost of non-Medicare dependents.

Commissioner Lim asked for the number of members affected in the retiree and family category in the UHC Medicare Advantage PPO and also Blue Shield's 65-Plus and the COB.

Marina Coleridge, HSS Data Analytics Manager, stated that there was one retired member in the UHC Medicare Advantage PPO with two or more dependents with no Medicare. There were 13 members in Blue Shield at the family rate with two or more Medicare dependents.

Action: None.

□ 06212016-03 Action item

Approve City Plan (UHC) self-funded rates and premium contributions for actives and early retirees for 2017 plan year with subsidy per the Self-Funded Plans' Stabilization Policy (Aon Hewitt)

Staff recommendation: Approve City Plan (UHC) rates and premium contributions for actives and early retirees with a $7.586 million subsidy from the City Plan Stabilization Reserve.

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

- Anil Kochhar reported that two options for actives and early retirees were presented at the May 12, 2016 meeting. However, Aon was asked to return with additional alternatives for the Board's consideration. See Aon report.
- The following two options were presented at the May 12, 2016 meeting:

- **Option 1**: Status quo with Self-Funded Plans' Stabilization Policy adjustment for active and early retiree rates for 2017 ($3,793,000 or $3.79M).
- **Option 2**: Self-Funded Plans' Stabilization Policy adjustment of $3.79M plus a one-time subsidy of $5.55M to the 2017 active and early retiree rates. ($3.79M + $5.55M = $9.34M) This proposal was not accepted by the Board.
- The following two options were presented at this meeting for the Board's consideration:
- **Option 3**: Self-Funded Plans' Stabilization Policy adjustment plus a one-time subsidy of $3.79M (50% of remainder of stabilization reserve) to the active and early retiree rates for 2017. ($3.79M + $3.79M = $7.59M) See **Option 3** rate cards on pages 5, 6, 7, 8.
- Option 3 would result in the employee-only contribution of $180.58 under the 93-93-83 contribution strategy (see page 5). The current employee-only contribution for 2016 is $85.65.
- Mr. Kochhar stated that if the Board approved upcoming Item 5, which would fund non-Kaiser retirees on a fully-insured basis, $2M in subsidy or claims stabilization would be added to the Medicare rate card. By policy, there is no requirement to subsidize fully-funded programs. Rates would not need to be adjusted on an ongoing basis to recoup deficit money or pay back surplus funds.
- **Option 4**: Fully fund City Plan and offer the UnitedHealthcare Medicare Advantage PPO, the "New Fully-Funded City Plan" in lieu of Blue Shield of California. This will allow for a one-time additional subsidy of $2M from Medicare's share of the stabilization funds to the 2017 active and early retiree rates, which is not required in the "New Fully-Funded City Plan," for a total subsidy of $7.59M. See **Option 4** rate cards on pages 9, 10, 11, 12.

- Under Option 4, the final employee-only contribution would be $85.65 versus Option 3, which is $94.93. See page 9 of report, which allows the application of more money to the self-funded portion of the rate card resulting in lower premiums.
- The remaining agenda items were discussed before the vote was taken on this item. Once decisions were made on items 1, 2, 4 and 5, the Board returned to vote on this item.
- Commissioner Sass moved to approve Option 4 of the rate card as presented.
- Commissioner Lim seconded the motion.

Public comments: Claire Zvanski, RECCSF representative, stated that she was rather overwhelmed looking at the proposed rates for the various options and wondered what the active employees would have to say. She understood that contribution strategies were agreed upon in bargaining agreements, but suggested that the active employees would be very surprised to discover that despite their bargained agreements, they would bear the greater burden of their healthcare rates, which was not the intent.

Action: Motion was moved and seconded by the Board to approve Option 4 of the rate card as presented for City Plan's self-funded rates and premium contributions for actives and early retirees for the 2017 plan year with subsidy per the Self-Funded Plans' Stabilization Policy.

Motion passed 4-1. Commissioners Scott, Breslin, Lim and Sass voted in favor of the motion. (Commissioner Breslin originally dissented but changed her vote.)

Commissioner Ferrigno dissented.

Supervisor Farrell was absent for the vote.

| | | | |
|---|---|---|---|
| □ | 06212016-04 | Discussion and possible action item | Approve City Plan (UHC) self-funded Medicare retiree rates and premium contributions for 2017 plan year with subsidy per the Self-Funded Plans' Stabilization Policy (Aon Hewitt)<br><br>Documents provided to Board prior to meeting: Report prepared by Aon Hewitt.<br><br>▪ Mr. Kochhar reported that the 2017 City Plan Medicare retiree premium rate increased substantially from $280.66 per retiree per month for 2016 to $362.85 per retiree per month for 2017 or 29.2%.<br><br>▪ See pages 4 and 5 of Aon's report for City Plan's 2017 self-funded Medicare retiree premium rate card and 2016/2017 plan year comparisons.<br><br>Public comments: None.<br><br>Action: None. |
| □ | 06212016-05 | Discussion and possible action item | Approve UHC Medicare Advantage PPO fully-funded proposal with retiree rates and premium contributions for 2017 plan year for all non-Kaiser Medicare retirees in lieu of retiree plans listed in agenda items 1-4 above (Aon Hewitt)<br><br>Documents provided to Board prior to meeting: Reports prepared by Aon Hewitt and UnitedHealthcare.<br><br>▪ Anil Kochhar reported that the purpose of this proposal was to present a more affordable option for retirees that did not disrupt providers, offered equal or better coverage and access, and allowed members a long-term sustainable program wherein the retiree-only category would not need to be supported with a retiree contribution.<br><br>▪ Due to the magnitude of the overall rate increase for Medicare retirees and other issues, Aon suggested that the Board consider the following solution offered by UnitedHealthcare:<br><br>▪ Change the funding status of the post-65 Medicare retirees under City Plan from self-funded to fully-funded. |

- Eliminate the Blue Shield of California ("BSC") 65-Plus (MAPD)/BSC Access+ (COB) plan and offer instead the UnitedHealthcare Medicare Advantage PPO. UHC's Medicare Advantage PPO includes all providers who accept Medicare and has a more generous EGWP drug formulary than the BSC product.
- Kaiser Permanente would remain available as an option (members would need to change doctors).
- The proposed 2017 plan options for Medicare retirees would include the UnitedHealthcare PPO Medicare Advantage and Kaiser Permanente. There would be no Blue Shield of California option for 2017.
- UHC offered significantly lower premiums and a two-year rate guarantee under its Medicare Advantage PPO option for Medicare retirees, resulting in a 4.5% increase in cost to the overall Medicare population versus a 13.8% increase.
- UHC expressed willingness to rebrand its Medicare Advantage PPO as the "New City Plan."
- The new fully-funded Medicare Advantage City Plan rate would be $320.83 per member per month with a cap at $336 in 2018.
- Mr. Kochhar stated that 89.5% of California physicians currently participate in UHC. He stated that UHC would present the specifics of its physician network as well as its EGWP.
- President Scott asked if UHC had discussed its EGWP calculations with him in contrast to Blue Shield not providing the same information.
- Mr. Kochhar stated that while he did not receive UHC's calculations for its EGWP formulary for the proposed new plan, UHC provided the calculations for its EGWP formulary for City Plan. UHC provided full disclosure.

- Mr. Kochhar turned the presentation over to UHC for further clarification on its 2017 proposal, the new fully-funded City Plan Medicare Advantage PPO.
- Jean Farone Jones, UnitedHealthcare Retiree Solutions representative, stated that since she first presented UHC's Medicare Advantage PPO to the Board in May 2015, there had been some changes. CalPERS has enrolled its population into UHC's Medicare Advantage PPO as well as AT&T, Wells Fargo and the State of Illinois.
- UHC anticipates over one million enrollees in its Medicare Advantage program in January 2017.
- Ms. Farone Jones presented provider access for California. Of the 7,617 physician providers in California, 6,800 will treat MAPD PPO patients or 94%. See page 5 of UHC's report.
- President Scott asked for clarification that the grid on page 5 included not only retirees located in the State of California but elsewhere in the United States.
- Ms. Farone Jones stated that the grid on page 5 of UHC's report was specific to California; however, UHC's network would cover retirees in all other states. National provider access was detailed in the Appendix. Currently, 19,617 physicians will treat MAPD PPO patients or 97.3% of HSS retires. See page 15 of UHC report.
- Ms. Farone Jones stated UHC's commitment to contact providers who have not yet submitted claims to UHC to ensure that they are informed about UHC's plan change, how to bill and gain familiarity with funding, so that there would be very little disruption for HSS retired members.
- There is no balance billing for covered services under the new fully-funded Medicare Advantage PPO plan. UHC will pay the provider the Medicare fee schedule and the member will pay only the co-pay amount and

nothing more. This fully-funded PPO has the same benefits in-network and out-of-network. Retirees will not need to change providers to access the in-network level of benefits.

- Many provider panels and providers across California overlap between UnitedHealthcare and Blue Shield.
- Commissioner Lim asked about the 801 providers on page 5 highlighted in yellow that UHC intends to contact regarding the proposed new plan. He also asked about the disruption of services to Blue Shield members who would move to the new UHC MAPD PPO plan and whether they would need to change primary care physicians.
- Ms. Farone Jones stated that the 801 providers included specialists. UHC will make contact to educate them on the new program.
- Ms. Farone Jones also noted that if Blue Shield retirees are currently utilizing Medicare physicians and that physician does not opt out of Medicare, those members will continue to have access to their doctors under the new UHC MAPD PPO plan. If the physician does not participate in Medicare, in an emergency, a member may access that physician and get full coverage, which is required by CMS by Medicare.
- If a member prefers access to a non-Medicare provider, they would pay for service and would not be reimbursed. This is called a private pay contract.
- President Scott asked if the private pay contract was in effect under the current PPO plan.
- Ms. Farone Jones responded affirmatively.
- Commissioner Breslin asked about private pay contracts last year out of concern that many specialty providers would take Medicare but not HMOs. She stated that the HMOs do not pay well for chiropractic or physical therapy and expressed concern that while the plan is a PPO, it pays like an HMO. She asked how UHC would track whether

members receive the same benefit. It may be difficult for some retired members to pay for services first and then send UHC the bill.

- Ms. Farone Jones stated that she researched the issue on physical therapists because she had watched the video from last year's Board meeting.
- When physical therapists are contracted in either the City Plan network or the fully-funded Medicare Advantage City Plan network, they are contracted with UnitedHealthcare and paid a per diem. They receive the same amount of money no matter how many services they provide.
- If a physical therapist is not contracted with UnitedHealthcare, they receive the Medicare fee schedule. They receive payment for the number of services provided and the member pays a copay.
- Ms. Farone Jones stated that if a member is told by their provider that they cannot access the same level of care under the new plan, to call HSS and escalate the issue to UHC. The provider will be contacted to ensure that the member receives appropriate care at the right time by the preferred provider.
- Commissioner Breslin also asked about preventive nutrition counseling, which is provided by Blue Shield but not UHC. This may be an issue with some Blue Shield members.
- Ms. Farone Jones stated that nutrition counseling is covered under UHC when it is in a primary care or provider office setting. It is also covered in connection with a diseased state. There is also pre-diabetes nutrition coverage for preventing diabetes.
- Ms. Farone Jones also called attention to page 7 of UHC'S report, which was a summary of a comparison of Blue Shield's copays and the UHC fully-funded City Plan copays.

- Commissioner Lim asked if a retiree living in New York whose primary care physician who does not accept Medicare would need to change physicians under the new City Plan.
- Ms. Farone Jones stated that the member would pay for the non-Medicare physician's services out-of-pocket in the new fully-funded City Plan and also the self-funded City Plan.
- If a member is unable to locate a physician in the new plan, UHC has a customer service model called "Advocate for Me," in which they will receive assistance from UHC's customer service department to find the appropriate provider.
- Commissioner Sass moved to approve the UHC Medicare Advantage PPO fully-funded proposal for the 2017 plan year for all non-Kaiser Medicare retirees in lieu of other retiree plans previously available.
- Supervisor Farrell seconded the motion.

Public comments: Antoinette Candelaria, retired City employee of HSS, stated that the proposal to move to a Medicare Advantage plan under UHC frightened her. She has been insured under City Plan for 23 years and is comfortable in knowing how it works, including the claims process. Many doctors do not accept HMO payments and there has been no time for retirees to contact their doctors to confirm whether this new plan will be accepted. Her confidence lies in the fact that she can see her doctors and know that City Plan will cover the services. She urged the Board to give retired members more time to review the proposal and research their doctors as many utilize the services of specialists. She also asked about the ease of the proposed Medicare Advantage plan and whether members will need to go through a primary care referral.

Herbert Wiener, retired City employee, stated that he was the beneficiary of a PPO and considered it an excellent plan. He expressed objection to the proposed UHC fully-funded plan stating that if Blue Shield was eliminated, Kaiser would be the only alternative. His concern was that there would be no

competition and once it has control, UHC could raise the premium rates and copays. He stated that this is an extremely dangerous proposal. If the PPO exists on the merits of its own plan, people will subscribe to it freely. However, he did not believe that UHC should be able to create a monopoly. And for that reason, he was opposed to the plan. Competition must be preserved to make all plans better.

Linda Long spoke on behalf of her parents, Hisia Long and Horace Long, since they have hearing deficits. They are both covered by Blue Shield and are happy with the plan. Horace Long was hospitalized with a stroke and was covered 100% under Blue Shield. Hisia Long was also hospitalized with kidney failure and diabetes complications. Mr. and Mrs. Long were concerned about how their medical bills would be handled under the proposed PPO plan and out-of-pocket costs. Kaiser would not be an option for her father because of the two-hour drive to Redwood City for treatment from specific specialists since the surgeons in San Francisco do not perform the types of procedures he requires. She expressed concern that her father would not seek treatment from Kaiser and would elect to forgo the required surgery. She asked the Board to delay making any changes to the current plan.

Claire Zvanski, RECCSF representative, stated confusion regarding reimbursement from the proposed new plan. She stated that some providers request payment prior to service and the member must seek reimbursement from their HMO or PPO. While these providers may be in-network, they are in essence balance billing the member who only gets back the Medicare reimbursement minus the copay. She expressed concern for potential abuse. Kaiser is the only medical plan that does not have that issue. On the positive side, Ms. Zvanski was happy to see providers in the Tuolumne area to serve retirees. However, her greatest concern was the lack of competition. In the past, the Board maintained as many options as reasonable for members. Over the years, there were usually at least two, three and in some instances more options for members to choose. Consolidating all retirees into one plan, removes the choice option, which Ms. Zvanski found problematic. She stated that it was a good plan but

had reservations about lumping everyone into only one option, especially where there were split families. The cost of healthcare will go up exponentially for those families in City Plan and there will need to be a way to balance the cost because many families are not all 100% Medicare.

Dennis Kruger, active and retired firefighters and widows' representative, asked for clarification on how split family coverage would work with the member and dependent(s) in different plans.

Commissioner Lim asked for clarification on what would happen with a retired 67 year-old Blue Shield member with a 59 year-old unemployed wife and two children under the age of 7. He asked if under the new proposal whether the retiree would be forced to enroll in the New City Plan and whether the member's wife and children would be allowed to remain in Blue Shield.

Mr. Kochhar responded affirmatively, stating that the retiree's non-Medicare dependents would be allowed to remain in the Blue Shield plan while the retiree would be enrolled in the new fully-funded UHC City Plan Medicare Advantage PPO. The PPO costs illustrated on the post-65 rate card would apply to the retiree and the pre-65 Blue Shield dependent costs would apply to the retiree's non-Medicare family members. The retiree's family would not be required to enroll in the City Plan, but would have that option. Under this scenario, the bill would include the cost of Medicare, paid at 100%, plus the dependent cost from Blue Shield.

Brett Sanchez stated that there was little clarity in the presentations and asked if the process could be slowed down and the vote delayed for one month to allow members to research doctors.

Butch Boyness, retired City employee, stated that he had been diagnosed with cognitive deficit which means that he will probably face early dementia and Alzheimer's. He will also require specialty care. He stated that it was premature to make a decision on a new healthcare proposal because it had not been discussed by the unions or the membership. The information presented was very confusing, which he felt created more anxiety for members. He stated that the UHC representative sounded like Donald

Trump to him—"Let's make America great again!" However, in making it great, there were things that were not said. A lot of doctors do not accept Medicare.

An unidentified male speaker asked since Blue Shield was willing to take on full dependent costs why would it not just lower rates and keep the people in its plan rather than splitting premiums between Blue Shield and UHC.

President Scott responded that Blue Shield's proposal was its full, final and best offer, which was articulated at the beginning of the meeting.

Maureen O'Shea, retired City employee, stated that retirees needed more time to consult their doctors regarding the proposed new plan.

Antoinette Candelaria, retired HSS employee, quoted the saying, "The devil is in the details," and stated there were not enough details to make a decision. She implored the Board to not accept the proposed fully-funded City Plan Medicare Advantage PPO.

Commissioner Sass stated that he was also a Medicare retiree. He had listened to all of the public comments and read all of the emails to the Board. He has been enrolled in Blue Shield 65 for the last three years and previously in the regular Blue Shield plan as an early retiree and City employee. He shared the same concerns as many of the retired members; however, in looking at all of the plan options, he expressed the view that this option was the best at this time.

Commissioner Breslin stated that she had heard from members who expressed there was not enough time to become familiar with the proposed new plan, which had just been released days earlier. She stated concern that eliminating competition and choices would create less transparency in City Plan. She could have voted for the Blue Shield plan although the dependent issue would need to be cleared up. She was told last year that the member and dependent would need to be 65 or older to enroll. She stated that one year of experience in the City Plan National PPO was not adequate time to determine a move to the new City Plan. The new UnitedHealthcare plan offered a 9.5% increase

without the 13,000 additional members from Blue Shield. That was a large increase for a honeymoon stage. With the additional 13,000 members, UHC offered a 4.5% increase or $323.83 PMPM for 2017 with a cap at $336 PMPM for 2018. She expressed concern that there was no way to control rates the following year, which the Board has experienced in the past. She saw no rush to make the proposed changes to City Plan and in fact did not find the current proposal such a great deal considering the originally proposed 9.5% increase compared to Blue Shield's proposed 10% increase. She questioned the sustainability of the proposed new plan and options for early retirees.

Commissioner Ferrigno asked if there was a way to separate UHC and Blue Shield and whether the vote needed to be taken at this meeting.

Director Dodd stated that the proposal was a combined Blue Shield offer for non-Kaiser retirees. The vote could not be postponed due to the Board of Supervisors deadline.

Commissioner Lim asked for a comment from a Blue Shield representative on the proposed new plan's impact on primary care physicians, hospitals and clinics. He asked whether UHC would cover all hospitals and clinics currently under Blue Shield.

Paul Brown, Blue Shield representative, stated that he could respond in general and would defer to UHC regarding its specific network. He added that Blue Shield had been as transparent as possible in the process and attempted to make every accommodation to make the proposed new option viable for HSS members, including the option for dependents, which it does not normally do.

President Scott asked Mr. Brown if Blue Shield had provided its best and final quote to the Board's actuary.

Mr. Brown responded affirmatively.

Action: Motion was moved and seconded by the Board to approve the UHC Medicare Advantage PPO fully-funded proposal for the 2017 plan year for all non-Kaiser Medicare retirees in lieu of other retiree plans previously available.

Motion passed 4-2. Commissioners Scott, Lim, Farrell and Sass voted in favor of the motion.

Commissioners Breslin and Ferrigno dissented.

President Scott stated that the Board had been dealing with Blue Shield rate increases and possible changes for more than a year. The issue was not new. While the specifics of the proposals just emerged, based on the ability of the actuary to obtain requested information from each of the health plans, the Board had anticipated the potential for substantial change and wanted to review it in a careful way that would mitigate the impact on retirees. UnitedHealthcare offered to accept HSS' retired population and will be under additional scrutiny. It will not go unnoticed by the Board if UHC has issues regarding customer service, providers or member benefits. He put UHC on notice stating that while the Board made the affirmative step in accepting its new fully-funded City Plan Medicare Advantage PPO, the Board will be relentless in assuring that quality of service provided to HSS retirees is as represented.

Commissioner Lim stated that having reluctantly approved UHC's proposal, he requested that UHC and the Board reach out to all retirees to provide a thorough explanation of the plan and address the disruptions. He suggested that UHC and HSS provide information at the RECCSF and POB monthly meetings with retirees.

President asked the actuary to address the question of the long term viability of City Plan in light of the approved change at the Board's meeting in August.

Commissioner Sass stated support for the Board's decision because (1) 93.8% of current services will be provided in UHC's network, (2) the new plan is less costly for retirees, including Kaiser (see page 18 of Aon's report) and (3) it reduces the City's costs, which is important for its GASB liability for post-retirement benefits.

□ 06212016-06 Discussion item Opportunity to place items on future agendas

Public comments: None.

- 06212016-07 Discussion item — Opportunity for the public to comment on any matters within the Board's jurisdiction

  Public comments: Claire Zvanski, RECCSF representative, stated that the passage of the new fully-funded City Plan Medicare Advantage PPO would require a major policy change in HSS' membership rules because the current rules state that all members and dependents must be enrolled in the same plan.

  Ms. Zvanski stated that for many years, the school districts looked for opportunities to remove its membership from HSS to seek lower cost health coverage elsewhere. She expressed concern regarding a potential unintended consequence that may cause the bifurcation of retirees out of the school district's system and allow its other employees to see plan coverage elsewhere thereby leaving their retirees in HSS. HSS has always been consistent that its membership could not be bifurcated. She also stated that by separating Medicare retirees from early retirees and actives and putting them into one single plan may have opened the door for future legal action.

  Dennis Kruger, representative for active and retired firefighters and their widows, asked if Blue Shield's agreement applied to Kaiser.

  Mr. Kochhar responded negatively.

  Sharon Johnson, Protect Our Benefits representative, stated that she was extraordinarily disappointed in the Board's vote. She stated that there was not enough notification for retired and active members to participate in this very important policy change. She asked that going forward, effort be made in the best way possible to contact members in ample time.

- Adjourn : 2:18 pm

## Summary of Health Service Board Rules Regarding Public Comment

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

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

## Disability Access

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

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

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

## Knowing Your Rights Under the Sunshine Ordinance

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

## Lobbyist Registration and Reporting Requirements

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

## Summary of Health Service Board Rules Regarding Cell Phones and Pagers

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

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

If any materials related to an item on this agenda have been distributed to the Health Service Board after distribution of the agenda packet, those materials are available for public inspection at the Health Service System during normal office hours. For more information, please contact Laini K. Scott at (415) 554-0662 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