HEALTH SERVICE BOARD
CITY & COUNTY OF SAN FRANCISCO

Minutes

Regular Meeting

Thursday, May 11, 2017

1:00 PM

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

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

President Randy Scott
Vice President Wilfredo Lim, excused
Commissioner Karen Breslin
Supervisor Mark Farrell, excused
Commissioner Sharon Ferrigno
Commissioner Stephen Follansbee, M.D.
Commissioner Gregg Sass, arrived 1:29 pm

This Health Service Board meeting was recorded live by SFGovTV. Links to videotaped meetings and related materials are posted on the myhss.org website.

This meeting was called to order at 1:08 pm.

- ☐ 05112017-01 Action item

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

- Regular meeting of April 13, 2017

Staff recommendation: Approve minutes.

Documents provided to Board prior to meeting: Draft minutes.

- Commissioner Breslin moved to approve the regular meeting minutes of April 13, 2017.

- Commissioner Ferrigno seconded the motion.

Public comments: None.

Action: Motion was moved and seconded by the Board to approve the regular meeting minutes of April 13, 2017.

Motion passed 4-0.

□	05112017-02	Discussion item	General public comment on matters within the Board's jurisdiction not appearing on today's agenda

Public comments: None.

□	05112017-09	Discussion item	President's Report (President Scott)

- Update on HSS Executive Director Search

Documents provided to Board prior to meeting: None.

- President Scott re-ordered this agenda item and asked Chanda Ikeda, DHR Director of Finance, IT and Contracts, to update the Board on the HSS Executive Director search. Ms. Ikeda attended the meeting in Christina Brusaca's absence.
- Ms. Ikeda stated that there was very little to report. Ralph Andersen & Associates was selected by the Board as the executive recruitment firm to conduct the HSS Executive Director search. The contract was with the Office of Contracts Administration for final signature, which typically takes approximately 30 days to review and execute. Christina Brusaca would follow-up in an attempt to expedite the timing.
- President Scott asked Ms. Ikeda to also assist in expediting Ralph Andersen & Associates' contract since he had hoped to receive an update on the process from the firm's representative at next month's meeting.
- President Scott reported on a webinar, "The first 100 days of the Trump administration," hosted by Aon Hewitt Consulting earlier in the month. He stated that it was an excellent overview and update on the House bill passed and implications. He distributed the

webinar materials to Board members prior to this meeting.

- The HSS Wellness Center will celebrate its third anniversary and be re-named in honor of former HSS Executive Director, Catherine Dodd. On May 19, 2017, a dedication ceremony will take place in the Wellness Center from noon to 2:00 pm. Dr. Dodd will be in attendance and Commissioner Follansbee will represent the Board. President Scott stated his intent to draft a letter for the event and will circulate it to Board members for comments.

Public comments: None.

RATES AND BENEFITS

☐	05112017-03	Discussion and possible action item	Approve SimpleTherapy musculoskeletal pain recovery through personalized exercise therapy (Helena Plater-Zyberk)

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

- Helena Plater-Zyberk, SimpleTherapy Chief Executive Officer, presented answers to three questions from the March meeting. She also reviewed SimpleTherapy's services as an online video-guided option for HSS employees and retirees for musculoskeletal pain, which can be performed on demand at home, 24/7.
- SimpleTherapy reviewed HSS' All Payer Claims Database ("APCD") from 2015-16 for pain-related claims (21%) and Ms. Plater-Zyberk noted that nearly $1M had been spent on opioids to treat related pain. She noted that Workers' Comp claims were not included in SimpleTherapy's analysis since additional costs were associated with it.
- One question from the March meeting was related to SimpleTherapy's overlap with existing HSS vendor services. Ms. Plater-Zyberk stated that only one plan offers limited online exercise video content. In addition,

physical therapy copays range from $20-25 per visit for the three HSS vendors.

- The second question related to the number of SimpleTherapy participants in California. Ms. Plater-Zyberk stated that approximately 4,000 participants across the United States utilized SimpleTherapy's online services in 2016; 153 participants were in California.
- The third question asked for the percentage of participants who first sought physical therapy prior to utilizing SimpleTherapy's services. Ms. Plater-Zyberk stated that 82% of respondents to an Aetna user survey indicated they had sought physical therapy as a first option. It was previously reported that this group considered SimpleTherapy more effective than physical therapy.
- Ms. Plater-Zyberk stated that should the Board elect to approve SimpleTherapy as an added benefit, employees would see it as an effective tool because its data shows 72% of users experienced decreased pain. She also stated that productivity should increase and absenteeism should decrease as employees utilize SimpleTherapy as a convenient option. It involves no paperwork, no copays, no appointments or transportation.
- SimpleTherapy has created a new fall and fracture prevention program for retirees to increase mobility and independent living as well as decrease the cost of hospitalization from falls. A marketing plan for CCSF has been developed by SimpleTherapy that includes month by month outreach to members to notify them of its availability as a benefit.
- SimpleTherapy would be available for the 2018 plan year at a cost of $0.29 PMPM ($29K per month or $358K per year). A pilot fall and fracture prevention program for retirees would also be offered free of charge from September through December 2017.

- Commissioner Breslin expressed concern about online physical therapy programs, noting that there is nothing like a hands-on experience with a physical therapist—the pain may not be where the problem is and can resonate from other places. Commissioner Breslin also questioned adding $30,000 per month ("PMPM") to the monthly rates. She suggested that SimpleTherapy contract with the health plans instead of directly with HSS.
- Commissioner Sass also expressed concern about encouraging members to start a physical therapy program without the involvement of their primary care physician. He stated that he was leery of internet medicine. In addition, SimpleTherapy is an expensive program. At $0.29 PMPM, it translates into $358,000 per year which covers over 14,000 copays. Commissioner Sass questioned whether it would offer a savings, noting that the amount paid by the employee is minimal, however, the City's costs would be significant.
- Commissioner Sass stated that he was disinclined to vote in favor of adding SimpleTherapy at this time.
- Commissioner Follansbee stated that as a retired physician, he would have welcomed a program such as SimpleTherapy to refer patients because of the difficulty in gaining immediate access to physical therapists. A program such as this does not cut patients from physician assessment, physical therapy assessment or physical therapy visits.
- In response to President Scott's inquiry, Acting Director Griggs stated that SimpleTherapy could be considered as a pilot program if the Board had uncertainty about purchasing the program directly versus through the health plans.
- President Scott stated that, as a precondition to his support of this program, a very explicit operational and strategic plan would need to be defined by SimpleTherapy to work with the health plans to ensure maximum return. He

also noted that a more proactive communications outreach effort was necessary. The pilot program would need to be driven by data from HSS' APCD to target specific employee/ retiree populations or departments while working with the health plans on member interactions. He stated that a standalone benefit did not make sense.

- Ms. Plater-Zyberk stated that SimpleTherapy's marketing plan introduced at the March meeting could be revisited, since it detailed the channels of targeted member communications and outreach. She also stated that SimpleTherapy would be open to working with HSS health plans as part of its strategic plan. She inquired about the timing of offering the benefit since integration into the medical plans could create a significant delay.
- President Scott stated that the process could be parallel but it needed to be explicitly understood that the strategic intent of the Board was to put the program into a business and implementation plan. The other question was how should the program be rolled out? The Board would need to decide whether to begin as a pilot project that may include some expense or a full-blown program.
- Commissioner Sass arrived during this agenda item.

Public comments: Catherine Dodd, former HSS Executive Director and recent early retiree, stated that she had injured her back while gardening during the third week of her retirement. Her primary care physician ordered physical therapy, however, Dr. Dodd took ibuprofen but did not perform the recommended exercises. She spoke of the convenience of utilizing an online program that starts by asking about the participant's pain level. If there is no pain improvement in three days, a doctor's visit is recommended. She is currently participating in an exercise and weight management buddy system that assigns her to two unknown partners for support, and has lost six pounds in two months. Dr. Dodd stated that fall prevention is key,

noting that Zuckerberg San Francisco General Hospital's largest ER visits are related to falls from people over 65 years old. She recommended added SimpleTherapy as a benefit and stated that HSS would miss an opportunity by not approving it.

Emma Erbach, Local 21 representative, stated that the union represents 5,300 CCSF employees, the majority of whom are office workers sitting at desks. She stated that most of these workers' jobs are sedentary and she sees the value in a program such as SimpleTherapy. She did not see it as an alternative to physical therapy but as preventive wellness instead. If employees could perform wrist exercises or stretches in the workplace on coffee or lunch breaks, productivity and wellness would drastically improve. She stated that there are no midnight physical therapy appointments or access to wellness programs for IT employees who work late at night and a program such as SimpleTherapy would be beneficial. She encouraged the Board to approve SimpleTherapy as a method to help employees avoid physical therapy appointments.

Herbert Weiner, retired City employee, stated that he has had physical therapy for back issues, which has been very beneficial. He, however, had several misgivings about SimpleTherapy, the first of which was cost. His second reservation was related to the lack of a comprehensive physical examination, noting that physical issues are not determined from the program. He stated that while physical exercises are beneficial, he did not think they should be offered through HSS and participation should be voluntary outside the System for employees who wish to partake in the program. It should not be in the HSS budget.

Claire Zvanski, RECCSF and SEIU 1021 West Bay Retiree Association representative, stated that a number of retirees have expressed interest and excitement in the SimpleTherapy program. One retiree reported experiencing more difficulty getting to and from a fall prevention class than the benefit of the class. One advantage in contracting directly through HSS is the elimination of additional administrative fees charged by HMOs for members as well as the convenience of participating from home. She stated that the SimpleTherapy program

would probably get her up and moving when the buzzer sounds as she would be participating according to her timing. Ms. Zvanski suggested that HSS members were worth $0.29 PMPM and asked the Board to consider the benefit.

Diane Urlich, UESF Retired Division, reported on this program at a recent membership meeting and attendees were very enthusiastic and looking forward to a program like SimpleTherapy. She has gone to Kaiser many times for physical therapy for her knee and back and has pages of exercises to do at home for the rest of her life. She stated that a daily computer reminder would most likely encourage her participation and suggested trying the program for a year.

Commissioner Sass stated that he would like to get baseline data and suggested that HSS start with the number of unduplicated physical therapy visits in the last year, the annual cost for each of the plans, member copay amounts, etc. If SimpleTherapy were to be considered as a pilot program, he would want the data to be the foundation for measuring improvement during the trial period. He stated that currently there was not enough hard data to begin to evaluate the program.

President Scott recommended deferral of this item until next month's meeting. He instructed HSS staff to work with SimpleTherapy to develop a pilot program for retirees, as previously offered. However, he requested more detail and the types of data described by Commissioner Sass to be included in the pilot plan to address the issues raised at this meeting.

Commissioner Follansbee objected because he considered the $0.29 PMPM fee a pilot. He questioned whether a pilot could be devised in a month's time since data on opioid use and the health plans' information may be incomplete, and this discussion will be taken up again next month.

President Scott suggested that the parameters of the pilot could be further defined and that while the per member per month amount may not change, member communications, the participation of the health plans, outreach, etc. can be clarified.

Action: No action taken. Deferred to June 8, 2017 meeting.

□ 05112017-04 Action item

Update on Best Doctors (second opinion vendor) and approve Best Doctors' rate confirmation (Aon Hewitt and Jon Fisher)

Staff recommendation: Approve 2018 Best Doctors' renewal.

- Jon Fisher, Best Doctors' Vice President of Business Development, presented data for the first two months of its program (January and February 2017).
- To date, Best Doctors has opened 200 CCSF cases and had 275 member contacts. During January and February 2017, 45% of diagnoses were changed and 91% of treatment plans were changed. (See page 6 of report for member utilization.)
- Members may contact Best Doctors several ways; however, most interactions are by phone call (85%).
- Two case examples from CCSF employees were presented: a 65 to 70 year old male former smoker with 4 millimeter lesions on his lungs and a 35 to 40 year old female who had undergone surgery for fibroid tumors and later began to experience additional bleeding. In each case, Best Doctors recommended a change in treatment.
- The male patient's original treatment plan recommended a follow-up CT scan at 12 months and no further imaging if no change was detected. The Best Doctors' expert recommended a CT scan at six months and then annually. This member was satisfied with Best Doctors' second opinion.
- The female patient's original treatment plan recommended another surgery to remove the fibroid tumor. The Best Doctors' expert agreed with the diagnosis and recommended trying a levonorgestrel IUD before considering surgery. This member was satisfied with Best Doctors' second opinion.

- Commissioner Follansbee responded to both case studies. He stated that the consultant had not referenced the guidelines used for the male patient's treatment, which would have been helpful since they were not consistent with published guidelines that he could easily find.
- Commissioner Follansbee reviewed the high risk guidelines from the American College of Chest Physicians, the National Cancer Institute and the Fleischner Society for Pulmonary Nodules updated last year. He noted that all of them recommended a follow-up CT scan at six to 12 months for small nodules 4 millimeters or less and no further follow-up, if no change.
- Commissioner Follansbee suggested that Best Doctors' consultants reference their guidelines when offering alternate treatment plans.
- Commissioner Follansbee stated that it was unclear whether the female patient's primary care physician offered alternate options to surgery. He also questioned the accuracy of the cost avoidance reported for this treatment ($18,703), since there was only a delay in treatment and additional costs could be involved with other procedures including hormone therapy.
- Mr. Fisher stated that that Best Doctors tries to be as accurate as possible with its cost savings methodology and seeks to be as transparent and conservative as possible.
- See page 13 of report for Best Doctors' 2017 member engagement campaign.
- Won Andersen, Aon Hewitt Senior Consultant, reported on the renewal for Best Doctors. She stated that the Board approved a three-year rate guarantee of $1.40 PMPM in 2016 through the end of 2019. While the data was limited, preliminary reports were positive. Therefore, Aon Hewitt recommended continuing with Best Doctors through the 2018 plan year.

- Commissioner Breslin asked why Best Doctors does not cover Workers' Comp cases.
- Mr. Fisher stated that Workers' Comp is very highly regulated and carrier approval is required for a second opinion. Best Doctors' Workers' Compensation team is working with Peggy Sugarman, CCSF Workers' Compensation Director.
- Acting Executive Director Griggs confirmed that conversations regarding covering services for Workers' Comp are currently taking place within DHR.
- Commissioner Breslin asked how Best Doctors determines the top doctors and noted that one could Google "best doctors" in San Francisco and find recommendations. She also asked when making referrals if Best Doctors verifies that physicians are accepting new patients.
- Mr. Fisher stated that Best Doctors uses a gallop certified database and each year identifies the top doctors/experts in the medical community to be included. It is a peer nominated process wherein doctors are asked to identify other physicians they consider to be the best of the best. He also confirmed that Best Doctors always makes sure that any doctor it recommends is accepting new patients and geographically located near the member.
- Commissioner Sass stated that he had hoped to see a more dramatic report, such as reversal or change in diagnoses through Best Doctors; however, confirmation was reassuring.
- Commissioner Follansbee stated that two months was not adequate time to make a negative decision regarding Best Doctors but noted that he had some concerns and hoped that the next report would address them. One concern was the selection of "best" doctors as a popularity contest, which he experienced when he practiced as an infectious disease physician and Chief of

Staff and President of the Medical Society. Another concern was regarding quality assurance. For serious problems, there should be feedback to guarantee quality assurance is followed up on and there are no liability for such issues. One issue would be whether members are using Best Doctors repeatedly and perhaps consider this service as an elective and not mandated as part of the health plans' offerings. Many members trust their providers and do not necessarily need to access this type of benefit, which is relatively expensive.

- Commissioner Breslin moved to accept the actuary's recommendation.
- Commissioner Sass seconded the motion.

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

Public comments: Herbert Weiner, retired City employee, asked if some of Best Doctors' physicians are located on the west coast such as UCSF, UCLA, UCSD, UC Davis, etc.

Mr. Fisher confirmed that Best Doctors' 53,000 experts are located all over the world, noting that 47,000 are located in the United States. He stated that the most doctor experts are located in California.

Catherine Dodd, former HSS Executive Director and new retiree, reported that she opened a Best Doctors' case related to her lymphoma diagnosis in 2013 while she was still an active employee and that it had closed last week. She had questions regarding medication that she should take for lymphoma as well as diabetes. Best Doctors' lymphoma recommendations confirmed Dr. Dodd's current treatment, which she found reassuring and she was put on a stricter diabetes regimen. She reported that getting her blood sugar in better control and exercising 150 hours per week were the result of her Best Doctors' report.

Claire Zvanski, RECCSF and SEIU 1021 West Bay Retirees' representative, reported that members have expressed appreciation for the addition of Best Doctors as a second opinion benefit since some did

not know how to work with their own health plans. She reported on a retired couple whose daughter had a rare eye condition and was a month away from turning 26. They consulted Best Doctors and another treatment was suggested, which avoided surgery. She stated that the City spends a lot of money on Workers' Comp-related injuries and suggested that those costs also be covered by Best Doctors even though it is covered as an employee benefit.

Action: Motion was moved and seconded by the Board to approve the recommendation to offer Best Doctors for the 2018 plan year at the guaranteed rate ($1.40 PMPM).

Motion passed 5-0.

□ 05112017-05 Action item

Approve Vision Service Plan's rate confirmation and buy-up option (Aon Hewitt)

Staff recommendation: Approve buy-up option with VSP administered enrollment.

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

- Tom Ricks, Aon Hewitt actuary, reported on Vision Service Plan's 2018 renewal, which is guaranteed through December 31, 2019 (2% rate reduction from 2016 premiums).
- In addition to its status quo renewal for 2018, VSP proposed a buy-up option for actives and retirees to purchase lenses, frames and contacts each calendar year instead of every 24 months. Benefits would no longer be tracked to the month of the prior year's services and allowed once each calendar year.
- The increase in cost for the buy-up plan would be paid completely by employees and retirees.
- VSP has offered HSS two rates for the administration of the buy-up option (see page 6 of report):
    - HSS Administration - $9.36 PMPM (employee only)

- VSP Administration - $10.86 PMPM (employee only)

- The HSS staff recommended to following:
  - confirmation of VSP's 2018 premiums, which represents a small change to current plan design with no change in premiums;
  - consider adding the buy-up plan alongside the status quo plan to offer employees and retirees additional choice (member would pay premium differential);
  - if approved, utilize VSP's enrollment services for the enrollment of members into this new vision plan.
- Commissioner Follansbee asked about the difference between Costco and non-Costco eyeglasses and questioned why members were penalized for seeking the best price. He also asked for the difference in annual cost if Costco matched other eyeglasses providers.
- Jennifer Carlson, VSP Market Director, stated that Costco's pricing is very different than marketplace because of its slight markup over wholesale. Since it has a different pricing model, Costco's reimbursement for frames is less than other retail businesses. If Costco matched other eyeglasses providers, the difference in annual cost would be a few percentage points.
- President Scott asked that Ms. Carlson calculate the percentage and share it with Acting Director Griggs to share with the Board before the next meeting.
- Commissioner Sass stated that the premium was roughly double under the buy-up. While he was not against the benefit, he stated that members should be aware of that fact.
- Ms. Carlson confirmed that increasing the frequency of the benefit doubles the premium. She noted the addition of two significant lens enhancements associated with the buy-up plan were also covered under

the $25 copay: anti-reflective coating (approximately $100) and progressive lenses (approximately $300).

- Acting Executive Director Griggs stated that HSS expects this benefit to be popular with members and anticipates 5,000 or more enrollments. This would require HSS staff to perform data entry for each member form in the PeopleSoft system, and is the reason for recommending VSP's enrollment services.
- Commissioner Ferrigno moved to approve the buy-option for VSP's renewal for 2018 plan year.
- Commissioner Breslin seconded the motion.

Public comments: Claire Zvanski, RECCSF representative, stated that retirees expressed enthusiasm when this benefit was first reported in the newsletter. She asked whether members could purchase the vision buy-up for one year or two and then opt out later if they chose to.

Acting Executive Director Griggs clarified that this benefit is similar to other pre-taxed benefits. Members may enroll one year and choose to not enroll the following, and will be compliant with HSS Membership Rules under section 125 Internal Revenue Code.

Karen (no last name provided), a retired teacher, stated that she loves VSP but reported on a recent issue with an unchanged progressives prescription that needed to be repeated three times due to poor lab work. The vendor paid for her lenses on the last return and sent them to another lab, which provided the correct prescription. She asked why VSP limited the number of times a vendor is allowed to fulfill a prescription.

Ms. Carlson, VSP representative, stated that VSP always wants to know about such situations. VSP will allow the member to select another lab due to unsatisfactory lab work and pay the claim. Under its choice network, VSP requires that all materials go through its lab to control costs; however, there can be mistakes with handling volume.

Action: Motion was moved and seconded by the Board to approve Vision Service Plan's buy-up option for the 2018 plan year.

Motion passed 5-0.

□ Meeting Break		Recess from 2:53 to 3:02 pm
□ 05112017-06	Action item	Approve Blue Shield Flex-Funded rates and premium contributions for Status Quo and Trio HMO proposal for actives and early retirees for 2018 plan year (Aon Hewitt)

Staff recommendation: Approve 2018 rates and premium contributions.

Documents provided to Board prior to meeting: Reports prepared by Aon Hewitt and Blue Shield of California.

- At President Scott's request, Acting Director Griggs presented background information for this renewal. He reported that Blue Shield's 2018 renewal for actives and early retirees included two options: the status quo Access+ HMO and new Trio HMO, an Accountable Care Organization ("ACO").
- Over the last few years, the Board has reviewed narrow network options. In June 2012, a fully-insured, aggressively priced Sutter Narrow Network was presented; however, the Board rejected that proposal and adopted flex-funding instead. In May and June 2016, the Board discussed a Sutter Health Plan option but no action was taken. However, at that time, UnitedHealthcare provided a financially favorable alternative for Medicare enrollees.
- The new Trio HMO offers as an alternative non-Kaiser HMO option to HSS membership that is more affordable than Blue Shield's current Access+ program. There is no change in copay; however, the physician and hospital networks include changes to current program components.

- Access+ will continue to include California Pacific Medical Center ("CPMC") in its hospital and physician networks; there is no change from the current plan.
- The 2018 proposed rate for Access+ is a 5% increase over 2017 premiums.
- The new Trio HMO matches Blue Shield's Access+ plan; however, CPMC is excluded from its hospital network. Sutter Health is also excluded from Trio's physician network.
- Trio's 2018 premium rates are approximately 10% less than Access+ 2018 premiums.
- Paul Brown, Blue Shield Area Vice President for Account Management, was joined by two colleagues to address the Trio Plan: Jeanette Mone, Account Manager, and Nitin Bhargava, Senior Vice President for Employee Markets. Dr. Pamela Laesch, Brown and Toland Senior Medical Director, was also in attendance to address clinical programs.
- Mr. Brown stated that the purpose of his presentation was to introduce Trio and describe how it would fit into Blue Shield's current plan offering. He noted that Trio is not new. Blue Shield has more than 100 customers enrolled in Trio and over 60,000 members throughout the State of California.
- Trio is an alternative HMO option for HSS actives and early retirees that is more affordable than the current Blue Shield of California Access+ program. It offers the same plan design with lower contributions and access to many of the same doctors that members currently use in Access+.
- In addition to Brown and Toland and Hill Physicians ACOs, there are other providers in the Trio network, such as John Muir and Meritage. California Pacific Medical Center ("CPMC") is not included in the Trio network in San Francisco nor is Novato Community Hospital in Marin County. However, Marin General Hospital is included in the Trio network.

- Seventy percent (70%) of HSS' membership currently utilizes Trio providers in the following Medical Groups:
    - Brown & Toland
    - Hill Physicians
    - John Muir
    - Meritage
    - Santa Clara Independent Physician Association
- Trio includes most of the hospitals associated with the above-mentioned medical groups. However, Sutter inpatient/outpatient providers and hospitals are not included in the Trio network.
- While CPMC is not included in the Trio network, HSS members will not incur out-of-pocket expenses in emergency situations, even if physician referred.
- In response to Commissioner Breslin's inquiry, Dr. Laesch stated that regular or prescheduled services, such as infusions, would need to be reviewed by a Brown and Toland medical director for medical necessity in order to be referred out-of-network. Pre-authorization must first be obtained. Requests are denied when insufficient reasons are given for out-of-network services.
- Jeanette Mone, Blue Shield representative, also reported that members with acute (short term) or chronic (ongoing) conditions would need to make a choice between Trio and Access+, since Sutter facilities are excluded from the Trio network.
- Mr. Brown reported that among the 17,000 HSS members enrolled in Brown and Toland, there were 379 admissions during the last 12 months (approximately 2.3%). Approximately 1,460 outpatient procedures were also performed, which equate to a total of 10% for Brown and Toland members. The other 90% of Brown and Toland's members did not

access any of CPMC's facilities during the last 12 months.

- San Mateo and Alameda counties are limited in access due to Sutter's domination in the Bay Area. Palo Alto Medical Foundation dominates in San Mateo County. Members in the East Bay wanting to utilize Alta Bates Hospital and providers in Berkeley and Oakland will want to remain with Access+.
- President Scott requested that Blue Shield take extra steps to communicate the limitations of the Trio network to HSS members. He noted that this will be a critical component on an ongoing basis, and not only during open enrollment.
- Commissioner Follansbee asked Dr. Laesch how many physicians had left Brown and Toland and Hill Physicians to go to the Sutter Foundation, which would impact access in 2018.
- Dr. Laesch confirmed that there has been physician migration to the Sutter Foundation. She stated that there are approximately 1,400 physicians (primary care and specialists) in Brown and Toland and approximately 83% of them have privileges outside the Sutter system. She could not report the exact number but stated that there are approximately 500 primary care physicians and 900 specialists.
- Commissioner Sass expressed concern regarding member migration out of CPMC, leaving those with more significant health and continuing care issues. He stated that this move could increase premiums for members remaining in Access+ and as a consequence, result in adverse selection in the CPMC market.
- Mr. Brown confirmed the cost differences between Trio and Access+, which is approximately 10%. Blue Shield took into consideration the migration and adverse selection issues raised by Commissioner

Sass. Blue Shield can try to prevent a death spiral by offsetting one or the other.

- Jeanette Mone, Blue Shield Account Manager, reported on Blue Shield's proposed Trio network communications to HSS members. They have been working with HSS staff for the last month on preliminary solutions. A robust rollout and member education are planned. It is important that clear and transparent communication is sent to members currently utilizing Brown and Toland primary care physicians. (See report for Trio network communications plan.)
- President Scott asked about post-open enrollment and continuing education communications to members regarding Trio.
- Ms. Mone stated that Blue Shield intends to continually educate members on Trio. They will also support HSS staff by providing onsite and WebEx training. Blue Shield staff will also be onsite at HSS in January and February and with HSS' permission, conduct outbound calls.
- In response to President Scott's inquiry, Dr. Laesch stated that there was an understanding that there will be a subset of patients who will need to continue with Sutter facilities, noting Brown and Toland is involved in multiple narrow networks through various payers. There are physician service representatives to educate physicians one-on-one on where to send patients.
- Commissioner Follansbee had several questions, a comment and suggestions. He asked about Dignity Hospital and abortion or other services that might not be available and whether members would need to go to another Trio hospital for those services. If that is the case, it is important for members to know where services are available and the nearest Trio hospital. He asked also if there was any anticipation of problems from Trio hospitals giving privileges in areas that have

a full bank of subspecialists in terms of competition.

- Dr. Laesch stated that she could not speak to the hospitals' reception to privileges and noted that Brown and Toland is contracted with all of the specialists at UCSF. She recalled a similar situation with a senior population when outpatient procedures were transferred from a more expensive hospital setting to an ambulatory surgery center. This involved contacting every specialist, and in that instance, there was no resistance from the physicians.
- Commissioner Follansbee asked for confirmation that current Blue Shield members who do not make a selection during open enrollment will be automatically enrolled in the Trio plan. He recalled the Board's previous negative experience with Blue Shield automatically enrolling members in programs and requiring them to opt out.
- Mr. Brown confirmed that Blue Shield members who do not make a selection will be automatically enrolled in Trio to give them lower contribution rate.
- Commissioner Breslin inquired about access to Trio in San Mateo County because it appeared that only Sutter was available on the diagram in Blue Shield's report.
- Ms. Mone reported that there are Trio providers in San Mateo County and Sequoia is the Trio hospital. Mills Peninsula is a Sutter hospital and not available under Trio. She noted that Alameda, Contra Costa, Santa Clara, San Francisco, San Mateo and Marin are all Trio counties.
- President Scott requested that Blue Shield prepare very clear listings on its maps and other information of available Trio hospitals county by county, zip code or any other effective method that will provide such detail. He requested the same information for Access+.

- Ms. Mone confirmed that Blue Shield would prepare clear communications indicating Access+ hospitals and Trio hospitals as well as providers. Custom letters and emails will also be sent to members based on their primary care physician selection. Blue Shield will follow up with post-enrollment education.
- Nitin Bhargava, Blue Shield Senior Vice President for Employer Markets, stated that Blue Shield is very committed to creating choice, competition and transformation of healthcare to obtain better outcomes for healthcare populations and lower costs. Trio was created to be transformative in nature as well as affordable and sustainable in the long term. Blue Shield is focused on making strategic investments with all of its provider partners to make Trio more than a narrow network but an HMO alternative that creates better value for the consumer.
- Commissioner Follansbee stated that he wanted to make sure his points were heard earlier because HSS has a responsibility to ensure women's care, including elective sterilization and abortion services. He thought that Sequoia was a Dignity hospital and if Trio were to pass, it would be important for members to know whether or not they would be able to receive these or other services (such as end of life) at the closest medical center.
- Mr. Bhargava stated that he clearly understood Commissioner Follansbee's earlier statements and that he had experience with faith-based systems. He was fully aware of the service lines those systems are focused on and services that are not included, such as some women's services, end of life care and several others. He stated that Blue Shield is not averse to considering bold ideas such as enhancing the care model or figuring out the investments needed to create healthcare delivery sites.

- Anil Kochhar, Aon Hewitt actuary, presented Blue Shield's 2018 proposal for Trio and Access+. The overall increase for Blue Shield's plan is 5.03% for actives and early retirees across all tiers. Rate cards were provided for the 93/93/83 and 100/96/83 contribution strategies for active employees.
- The 2018 10-County average used to calculate early retiree rates is $649.17 or an increase of 7.33%.
- The rates for the Trio plan are approximately 10% lower than the 2018 status quo HMO Access+ renewal rates.
- Commissioner Breslin expressed concern regarding the family rates for early retirees.
- See Aon Hewitt report for analysis and rate cards.
- HSS' staff recommended that the Health Service Board approve Blue Shield's alternate proposal offering employees two plan choices: current Blue Shield network and the Trio network.
- Commissioner Follansbee moved to accept the HSS staff recommendation to proceed with two plan options for employees and early retirees for the 2018 plan year: current Blue Shield network and the Trio network.
- Commissioner Sass seconded the motion.

Public comments: Emma Erbach, Local 21 representative, stated that Local 21 supported the Trio HMO option and believed that it was the right choice for HSS. She urged the Board to add the Trio plan to give employees a lower cost option while also keeping Access+ available for members who want it. She had spoken with many members unable to attend this meeting who supported a lower cost healthcare option and do not like Sutter, whose costs are increasing. She stated that an appendectomy costs 20% more at CPMC than Dignity for no reason. She also supported a plan that encouraged competition. She stated that if the

Board passed Trio, Local 21 would also communicate with its members about the new option through its newsletter, monthly meetings and email blasts.

Catherine Dodd, former HSS Executive Director and early retiree, stated that Blue Shield is a good insurance citizen. No insurance company is without black marks, however, Blue Shield was committing to a non-Kaiser HMO option in the Bay Area to create competition on a level playing field in terms of risk with Sutter so that Sutter will begin to decrease its rates. Blue Shield has worked diligently with HSS on the ACOs, which took a lot of extra time and money to create. Dr. Dodd noted that over the last six years, Sutter Hospital was not present at the majority of ACO meetings or sent someone different to each meeting, which made it very difficult to hold its feet to the fire. She stated that Brown and Toland was unable to meet its targets because of Sutter Hospital. A Board of Supervisors' hearing proved that Sutter overcharges. Trio creates an opportunity for Blue Shield members to not pay for members choosing to access Sutter yet allows them to choose a network that has all of the benefits of the HMO plan option. Lastly, quality matters. Research on the internet through California Quality Care showed that two of the four Sutter hospitals in San Francisco are ranked below average. Dr. Dodd stated that HSS should not even participate with them. The other two Sutter hospitals are ranked average. Within the Trio Hospital system, UCSF is ranked above average and Dignity Hospitals are ranked average. She urged the Board to approve this option for members.

Claire Zvanski, SEIU 1021 representative, concurred with the comments of Dr. Dodd and Ms. Erbach. She remembered when HSS joined the ACOs and that it was a very exciting time. She encouraged the Board to do what it could to mitigate the high costs of healthcare for early retirees since many of them still have under age dependents, which can be significant.

Herbert Weiner, retired City employee, reported that his doctors are primarily in CPMC and noted that they charge exorbitant rates. He hoped that CPMC can "clean up their act" so that Trio can include them in its network. He stated that everything

presented to date was very complex and that he hoped to make some sense of it all.

Action: Motion was moved and seconded by the Board to accept the HSS staff recommendation to add the Trio plan option to Blue Shield's current network for the 2018 plan year.

Motion passed 5-0.

☐ 05112017-07 Action item

Approve Kaiser Permanente rates and premium contributions for actives and early retirees for 2018 plan year (Aon Hewitt)

Staff recommendation: Approve 2018 rates and premium contributions.

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

- Anil Kochhar reported that Kaiser Permanente's renewal slightly increased the contributions of active employees under both the 93/93/83 and 100/96/83 contribution models. (See rate cards on pages 6 and 7 of report).
- Cindy Green, Kaiser Permanente Senior Executive Account Manager, reported on a benefit enhancement for the 2018 plan year. The new benefit enhancement includes an additional cycle of IVF, ZIFT and GIFT per lifetime. Previously, the benefit included only one cycle. Effective 2018, this benefit will include two cycles up to a lifetime maximum.
- Aon Hewitt recommended that the Health Service Board approve Kaiser Permanente's rates and premium contributions for actives and early retirees.
- Aon Hewitt also recommended delaying the funding mechanism decision (fully-insured vs. risk-sharing arrangement) to the August Board meeting.
- Commissioner Breslin moved to accept the actuary's recommendations.
- Commissioner Ferrigno seconded the motion.

Public comments: None.

Action: Motion was moved and seconded by the Board to accept the actuary's recommendations to approve Kaiser Permanente's rates and premium contributions for actives and early retirees for the 2018 plan year, and delay the funding mechanism decision until the August meeting.

Motion passed 5-0.

□ 05112017-08 Action item

Approve UHC (City Plan) self-insured rates and premium contributions for actives and early retirees for 2018 plan year (Aon Hewitt)

Staff recommendation: Approve 2018 rates and premium contributions.

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

- Mr. Kochhar reported that the additional subsidy strategy increased City Plan's membership over the past several years (33% increase in active membership and 23% increase in early retiree membership).
- Claims stabilization funds were used in 2016 and 2017 to reduce rates with the intention of maintaining the long term sustainability of City Plan. The 2016 claims experience was positive thereby creating a surplus for the calendar year of $736,000, which increased the claims stabilization balance to $4,529,000 as of December 31, 2016.
- At the February 9, 2017 meeting, the Board approved applying $1,510,000 to City Plan's 2018 rates for actives and early retirees. This leaves a balance of $3,019,000 available for the 2019 plan year.
- Aon's report included two rate cards for 2018:
    - Status quo for actives and early retirees
    - Additional buy down of $1,510,000, which is 50%
- Mr. Kochhar asked to return in June to bring more options for the Board's review. He suggested an option for an additional buy down for actives only, not early retirees. He

has reviewed this option with Acting Executive Director Griggs who indicated that the Board would need to approve.

- President Scott took the prerogative of the Chair and directed that this item return in June.

Public comments: None.

Action: None.

REGULAR BOARD MEETING MATTERS

□ 05112017-10 Discussion item Director's Report (Acting Executive Director Griggs)

- HSS Personnel
- Operations, Data Analytics, Finance/ Contracting, Communications, Well-Being/EAP
- Meetings with Key Departments
- Other additional updates

Documents provided to Board prior to meeting:

1. Director's report;
2. Reports from Operations, Data Analytics, Communications, Well-Being and Employee Assistance Program;
3. Revised rates and benefits calendar;
4. Commissioner Breslin report on medical plans' responses regarding current nutrition counseling coverage;
5. Commissioner Follansbee report on medical plans' responses regarding 2015 DMHC Timely Access Report.

- Due to time constraints, this item was deferred until next month. However, Acting Executive Director Griggs reminded the Board of the HSS Wellness Center's re-naming event reported at the beginning of this meeting (the Catherine Dodd Wellness Center).

Public comments: None.

□	05112017-11	Discussion item	HSS Financial Reporting as of March 31, 2017 (Pamela Levin)

Documents provided to Board prior to meeting:

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

- Pamela Levin, HSS Chief Financial Officer, reported that the projected trust fund balance by June 30, 2017 is $73.4M, which is $100,000 less than reported last month. The variance is due to unfavorable claims experience for the self-funded City Plan.
- The first surrogacy and adoption reimburse-ment was made this month in the amount of $7,000.
- Ms. Levin also reported on how performance guarantees are incorporated into HSS contracts. As of this date, the performance guarantee balance is $7.644M (a payment of $44,000 was received last week). See memo.
- Commissioner Sass expressed concern regarding the contingency balance for City Plan's and Blue Shield's projections. He stated that HSS cannot continue to pour $10M a year into plans and cannot continue to absorb $12M in losses with the Access+ experience.
- Ms. Levin reported that she was preparing to go into the more difficult part of the budget process with the Budget Analyst and that she hoped to return with HSS' budget intact.
- President Scott stated that he and other members of the Board were ready to assist in the process and expect Ms. Levin to alert them when they are needed.

Public comments: None.

□ 05112017-12 Discussion item Report on network and health plan issues (if any)
(Respective plan representatives)

- Commissioner Breslin had previously requested that each health plan report on current nutrition counseling available to members and asked for the information.
- Acting Executive Director Griggs stated that the report will be presented next month since it was included in the Director's Report, which was deferred earlier.

Public comments: None.

□ 05112017-13 Discussion item Opportunity to place items on future agendas

- Catherine Dodd, former HSS Executive Director and early retiree, asked the Board and HSS staff to actively pursue SB 853, which is legislation that eliminates anti-competitive practices by health systems. She stated that the hang up was the City's Public Health Department because public health hospitals that are part of the Hospital Association do not want transparency. She stated that HSS and the Board have demanded transparency for the last seven years and it is time for the department and the Board to challenge the Department of Public Health. She noted that the SF Board of Supervisors held transparency hearings, which she felt were overlooked. It was a tremendous amount of work for HSS. The Pacific Business Group on Health is woefully disappointed that HSS has not been of more assistance in terms of getting the City to take a position.
- President Scott asked Acting Executive Director Griggs to bring this subject up with the Board next month and perhaps prepare a resolution for the Board to act on.

Public comments: None.

□ 05112017-14 Discussion item Opportunity for the public to comment on any matters within the Board's jurisdiction

Public comments: None.

- Adjourn: 5:10 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.

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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