HEALTH SERVICE BOARD
CITY & COUNTY OF SAN FRANCISCO

Minutes

Regular Meeting

Thursday, May 12, 2016

1:00 PM

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

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

President Randy Scott
Vice President Wilfredo Lim
Commissioner Karen Breslin
Supervisor Mark Farrell, arrived 1:13 pm
Commissioner Sharon Ferrigno, excused
Commissioner Stephen Follansbee, M.D.
Commissioner Gregg Sass

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

This meeting was called to order at 1:05 pm.

- ☐ 05122016-01 Action item

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

- Regular meeting of April 14, 2016

Staff recommendation: Approve minutes.

Documents provided to Board prior to meeting: Draft minutes.

- Commissioner Breslin moved to approve the regular meeting minutes of April 14, 2016.
- Commissioner Lim seconded the motion.

Public comments: None.

Action: Motion was moved and seconded by the Board to approve the regular meeting minutes of April 14, 2016.

Motion passed 6-0.

□	05122016-02	Discussion item	General public comment on matters within the Board's jurisdiction not appearing on today's agenda

Public comments: None.

□	05122016-12 Re-ordered	Discussion item	President's Report (President Scott)

Documents provided to Board prior to meeting: None.

- President Scott claimed the privilege of the chair and re-ordered this item. He stated that first and foremost, the rates and benefits process is one of the most important responsibilities of the Health Service Board, and that the Board had a duty to review a wide range of issues each year. To underscore that fact, he noted the educational forum conducted in November 2015, and his intent to hold another such forum in the fall, if he is reelected as President of the Health Service Board.
- President Scott stated that he had received queries as well as email petitions (along with the other Board members) regarding the following agenda item (the consideration of adding Sutter Health Plus network for the 2017 plan year). He asked that members listen to the discussion with open minds. He also stated that public comment on agenda item 3 would be restricted to two minutes. He encouraged commenters sharing the same view expressed by a previous speaker to note concurrence but also stated his intent to not dampen free speech.
- President Scott thanked Aon Hewitt for all of the items brought before the Board, as well as HSS staff and Director Catherine Dodd.

Public comments: None.

RATES AND BENEFITS

□ 05122016-03 Action item

Consider approval of Sutter Health Plus proposed rates and premium contributions for actives and early retirees for 2017 plan year (Aon Hewitt)

Staff recommendation: Defer proposal and allow for consideration during the 2018 Rates and Benefits deliberation.

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

- Anil Kochhar, Aon Hewitt actuary, reported on the proposal submitted by Sutter Health Plus.
- Sutter Health Plus submitted a high-level plan design comparison of its proposed plan to the existing three HSS providers (Blue Shield of California HMO, Kaiser Permanente HMO and UnitedHealthcare PPO). See pages 3-12 of report (see highlights indicating plan differences).
- Sutter is currently a contracted vendor of Blue Shield's, which includes the Brown and Toland Medical Group Accountable Care Organization ("ACO"). The table on page 13 of Aon's report lists the members of Blue Shield's flex-funded plan (a total of 36,624 members). Sixty-three percent (63%) or 23,182 Blue Shield members are associated with Sutter doctors. The remaining members not associated with Sutter doctors or the Sutter Health Plan (13,442) would need to move to City Plan if they wanted to retain their Sutter doctors.
- Commissioner Follansbee asked if Sutter intended to withdraw from the Brown and Toland ACO should the Sutter Health Plan be accepted as a new network option for HSS members.
- Mr. Kochhar stated uncertainty and asked whether Blue Shield or Sutter wanted to respond to the question.
- Paul Brown, Blue Shield of California account manager, stated that for the past five years,

Blue Shield has partnered with two separate ACOs: Brown & Toland and CPMC; and Hill Physicians, Dignity and UCSF. If Sutter Health Plus were to be selected as a health plan option, Blue Shield would not be a part of that ACO collaboration. He asked the Sutter representative to comment.

- Ron Carnaroli, Sutter Health Plus representative, stated that Sutter Health had a contractual relationship with Brown and Toland, and that CCSF members would be able to obtain services in addition to the other providers listed on page 13.
- Mr. Kochhar noted that the disruption analysis on pages 15, 16 and 17 of the report indicated inpatient and outpatient costs presently funded by HSS through flex-funding with Blue Shield that would be excluded under the Sutter Health Plan, a total of $26.48M. Mr. Kochhar stated that a new network would need to be created for the 13,442 people who did not have Sutter doctors, which could be at a much higher rate than Sutter's current proposal.
- Sutter Health Plus proposed a 24-month rate guarantee effective January 1, 2017 through December 31, 2018, as well as a rate cap of 5% for 2019.
- Aon prepared and compared rate cards for the 93-93-83 and 100-96-83 contribution models negotiated through active members' MOUs for all HSS health plans. Sutter's numbers were less than the present combined Sutter/non-Sutter numbers under flex-funding through Blue Shield.
- Mr. Kochhar reiterated the need for the creation of an efficient and effective new plan for the remaining 13,442 members if the Board decided to add the Sutter Health Plan network. He stated that, at the current time, there were no vendors ready to create a comparable new plan.

- Mr. Kochhar read aloud Aon Hewitt's recommendation, which may be found on page 32 of the report. In the actuary's opinion, it was premature to approve Sutter Health Plan's proposal for the 2017 plan year for the following reasons:
    - The major disruption of 13,442 lives in the overall population presently covered by Blue Shield of California;
    - The largest portion of potential enrollees in the Sutter Health Plan are presently enrolled the Brown and Toland CPMC ACO, which to date, has been unable to attain established claims targets. The ACO must achieve claims at or below target before the Health Service Board will consider the rate structure proposed by Sutter Health Plus;
    - The non-Sutter Health Plus vendors were unable to offer programs alongside Sutter Health Plus at this time.
- Aon Hewitt recommended that the Health Service Board table the Sutter Health Plus network proposal for at least one year to allow time for a thoughtful plan offering to be developed for a non-Sutter Health Plus network to be presented in conjunction with Sutter Health Plus.
- Commissioners Lim asked for clarification on the disrupted 13,442 Blue Shield members and whether they would lose access to doctors.
- Mr. Kochhar stated that the disrupted members were associated with either Hill Physicians or other doctors not associated with Sutter. If the Sutter Health Plan network was offered, those members would have only Brown and Toland as an option. If they did not want to change doctors, a program for those members would need to be created.

- Commissioner Follansbee asked if the disrupted 13,442 members would lose access to non-Sutter facilities.
- Mr. Kochhar stated that those members would not lose access to non-Sutter facilities, however, they would have to pay more.
- Commissioner Sass stated that while Sutter Health Plan's proposed premiums appear to be lower, the cost of healthcare may not be. He cited the comparison of Blue Shield's hospital admittance copay to that of Sutter Health Plan. Sutter Health Plan's hospital costs are $500 per day up to five days or $2,500 for inpatient care (see page 3 of report) compared to Blue Shield's inpatient hospital copay of $200 per admission. Blue Shield members are allowed 100 days per benefit period at a skilled nursing facility at no charge. Sutter Health Plan charges $200 per day allowing 100 days per plan year.
- President Scott stated that the actuary's recommendation to "table" Sutter Health Plan's proposal was inaccurate and that the correct term should have been to "defer" or postpone action on this item until the 2018 renewal cycle.
- Commissioner Lim moved that the Board not consider the Sutter Health Plan proposal for the 2017 plan year.
- Commissioner Follansbee seconded the motion.
- President Scott gave the Sutter representative an opportunity to comment.
- Rob Carnaroli, Sutter Health Plan representative, stated his view that Sutter offered a strong alternative to the current health plans available through HSS carriers. He said, however, that Sutter's intention was not to replace any of the current carriers. He stated that Sutter attempted to demonstrate a long-term commitment to CCSF by providing a third-year cap in addition to its two-year agreement. Sutter had developed a provider-

sponsored health plan that was the next generation of healthcare.

- President Scott stated that public comment would be restricted to two minutes. In the interest of time, he asked anyone fully agreeing with a prior public comment to state as much, making way for the next commenter.

Public comments: Robert Muscat, Executive Director of Local 21 and Chair of the Public Employee Committee ("PEC"), stated that the recommendation on this issue was headed in the right direction and he did not want to say anything to upset the course. He stated that the PEC represented all unions for the 25,000 active City employees, including members of the Municipal Employee Association (managers). The PEC has tackled big issues in the past, including working with the Mayor's office on retirement problems and retiree health issues with Supervisor Farrell, for example. The PEC allows 25 different unions to come together to do things that are not only sensible for the City but also the residents of San Francisco who count on City services. He stated that all of the unions were united in asking the Health Service Board to not move forward with the addition of the proposed Sutter Health Plan. Mr. Muscat expressed opposition to approving any additional business with Sutter, stating that it was a very anti-union company. The PEC had recently come before the Health Service Board to ask that it join the United Food and Commercial Workers lawsuit against Sutter. The last thing they would want is for the Board to find a way to do even more business with Sutter.

Ed Kinchley, SEIU 1021 representative, stated SEIU's opposition to adding a Sutter HMO plan, and voiced support for the motion. He stated that Sutter was attempting to enhance its market share in order to increase its prices and revenue, not decrease prices. He mentioned a New York Times article from several years ago that highlighted the lack of hospital transparency and used San Francisco's CPMC as an example. The article stated that CPMC was the state's largest private non-profit hospital in California with the highest income at the time. The prices for many procedures at CPMC were among

the top 20% in the country. The author, Glenn Melnic (Professor of Health Economics at University of Southern California) stated that, "Sutter's a leader, a pioneer in figuring out how to amass market power to raise prices and decrease competition." Mr. Kinchley concurred with Mr. Muscat's statement regarding UFCW's lawsuit against Sutter.

Theresa Rutherford, SEIU 1021 representative, expressed opposition to the addition of a new Sutter HMO and agreed with the previous speakers' statements.

Robin Ho, active 17-year CCSF employee and proud Local 21 member, echoed the previous comments and stated that she supported the decisions of her union.

Larry Griffin, active 21-year CCSF employee and Local 21 member, encouraged the Board to vote against adding the Sutter Health Plan HMO. He stated that while he supported competition in the healthcare market, members needed protection from a predatory company such as Sutter. He stated that there would be no protection from Sutter's predatory rate hikes if they are added to HSS' healthcare vendors. HSS members do not need another health plan if it is not beneficial to all members in the long-term.

Carmen Herrera, Local 21 member and at large president of a chapter close to 400 members, stated that HSS members already had HMO choices and that the Board should not support a contract with Sutter Health HMO due to its anti-union activities toward its members and workers. She noted that her sister, a nurse, was treated very badly by Sutter HMO as an employee. She asked the Board to vote no on adding the Sutter Health Plan.

Chris Moyer expressed concern on behalf of 1,000 rank and file pile drivers as well as 30,000 carpenters in Northern California regarding adding the proposed Sutter Health Plan HMO. He stated concurrence with the previous speakers and urged the Health Service Board to refrain from subjecting CCSF workers to a Sutter Health HMO.

Jeff Duritz, spoke on behalf of UAPD, the union representing physicians and dentists. He expressed opposition to the inclusion of the Sutter Health Plan HMO. Since the motion to defer action on Sutter until next year was on the table, he opted to present very specific details regarding why the Health Service Board should outright reject Sutter at that time.

Claire Zvanski, representative of RECCSF, SEIU 1021 West Bay retirees and the newly formed IFPTE 21 retirees, stated concern that the Sutter Health Plan HMO was not an affordable option. She stated that at $500 per day (up to five days) for a Sutter hospitalization compared to current hospital admission copays of $100 to $200 was horrible cost shifting. She added that there was no reference to coverage for Medicare retirees, not to mention members in Tuolumne and Hetch Hetchy. And as such, she considered this proposal an incomplete submission. She expressed doubt that even if the proposal was deferred another year, it would not change much. It would be in Sutter's best interest to work with Blue Shield and UnitedHealthcare to negotiate lower rates for the benefit of all members. If they are sincere about being included as a new network, Sutter should be talking about lowering its rates so that its facilities and providers are much more affordable. She expressed the hope that in the future, the Health Service Board will only consider plans that best serve all members and provide affordable coverage, especially for retirees on very fixed incomes.

Camaguey Corvinelli, Municipal Executives Association business agent, asked to go on record that the MEA stood with labor and opposed the City doing business with Sutter.

Dennis Kruger, active and retired firefighters' representative, stated that his organization concurred with all of the previous speakers.

Emma Erbach, Local 21 representative, stated that in addition to the issues raised by the previous speakers, there was concern regarding the overall cost to the employer. Currently the City spends approximately $700,000 per year on healthcare. If overall healthcare costs spike, there would be less

money available for other healthcare needs or City services. She strongly urged the Board to reject the addition of Sutter Health Plan HMO entirely and not bring it back in the future.

Herbert Weiner, retired City employee, strongly supported the rejection of Sutter Health Plan. He stated that it should be voted down unanimously, and not tabled.

Action #1: Motion was moved and seconded by the Board to not consider the Sutter Health Plan proposal in the 2017 plan year.

Motion passed 5-1.

Commissioner Scott dissented.

- Commissioner Scott moved that the Health Service Board not consider the Sutter Health Plan in 2017 or in 2018.
- Commissioner Lim seconded the motion.

Additional public comment: Commissioner Breslin did not see a reason for the motion as it did not indicate when to next consider the item.

Commissioner Follansbee stated that a lot could happen in two years, especially since it is unclear how healthcare will be impacted by the next presidential election.

Commissioner Sass expressed concern regarding several issues—member disruption, inpatient/ outpatient costs and copays as well as Blue Shield's struggles to keep its premiums reasonable in light of Sutter's costs. He expressed a preference to keep the door open for considering an alternative to the current plan in a year's time if it is in the interest of all members.

Action #2: Motion was moved and seconded by the Board to not consider the Sutter Health Plan proposal in plan year 2017 or 2018.

Motion failed 5-1.

Commissioner Scott dissented.

□ 05122016-04 Action item

Approve Kaiser Permanente's rates and premium contributions for actives and early retirees for 2017 plan year (Aon Hewitt)

Staff recommendation: Approve 2017 premium contributions for actives and early retirees.

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

- Anil Kochhar reported that Kaiser Permanente's premium increase for the 2017 plan year is approximately 5% across all rating tiers.
- Kaiser's rates are currently under a two-year guarantee that expires on December 31, 2016. The 2017 rates for actives and early retirees increased by 4.79% for medical and pharmacy coverage.
- Included in Kaiser's premiums are costs for vision, Healthcare Sustainability ($3.00 PMPM) and Best Doctors (second opinion benefit). See page 3 of report.
- See page 4 of report for the underwriting premium rate buildup for active employees.
- See pages 6-9 for the 2017 active employee and early retiree renewal premiums and contributions and rate cards.
- Cindy Green, Kaiser Permanente Executive Account Manager, reported on two benefit changes for the 2017 plan year:
    - $15 copay for either chiropractic or acupuncture services (or any combination) for up to 30 visits per year;
    - A 20% coinsurance specialty tier pharmacy benefit not to exceed $100 per prescription.
- Commissioner Follansbee asked if a list of preferred outside network acupuncturists would be provided by Kaiser.
- Ms. Green responded affirmatively and stated that the chiropractic benefit was through the American Specialty Health Network as part of

Kaiser's rider. A Kaiser member may self-refer to an acupuncturist or chiropractor not affiliated with Kaiser Permanente. No prior authorization is necessary and requires a $15 copay.

- Director Dodd asked for clarification regarding coinsurance up to $100 per prescription.
- Ms. Green stated that prescriptions are capped at $100 each. Approximately 98% of all specialty medications are provided in a supply of 30 days or less.
- Commissioner Breslin moved to approve Kaiser Permanente's rates and premium contributions for actives and early retirees for the 2017 plan year, as presented.
- Commissioner Sass seconded the motion.

Public comments: Claire Zvanski, RECCSF representative, acknowledged Kaiser's low rate increase but also pointed out that costs for early retirees with dependents remain high at $760 per month. She stated that very often early retirees go out on a lower type of retirement or disability. The retiree organizations are watching those issues closely out of concern for the early retirees and their ability to continue to insure their families while, in many cases, being forced to retire before age 65.

Action: Motion was moved and seconded by the Board to approve Kaiser Permanente's rates and premium contributions for actives and early retirees for the 2017 plan year.

Motion passed 6-0.

□ 05122016-05 Action item

Approve Blue Shield Flex-Funded Non-Medicare rates and premium contributions for actives and early retirees for 2017 plan year (Aon Hewitt)

Staff recommendation: Approve 2017 premium contributions for actives and early retirees.

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

- President Scott asked Mr. Kochhar to review the summary, highlight the rate card and present Aon's recommendation.
- Mr. Kochhar reported that the overall increase for the Blue Shield flex-funded plan is 4.26%. This rate includes flex-funded medical and pharmacy costs, the claims Rate Stabilization Reserve amortization, vision, HSS Sustainability Fund and second opinion costs. See summary on page 2 of report.
- See pages 6-9 for the active employee and early retiree contribution strategies (93-93-83 and 100-96-83) and 2017 flex-funded monthly rate cards.
- Commissioner Lim asked if there were any changes in Blue Shield's plan design for the 2017 plan year.
- Paul Brown, Blue Shield representative, stated that there were no plan design changes this year.
- Director Dodd stated that Blue Shield was adding a LifeLock benefit for the next plan year.
- Mr. Brown stated that as part of a Blue Shield Association requirement and mandate, all Blue plans throughout the country must offer an identity protection product, such as LifeLock. This program will be on an opt-in basis for all actives and early retirees.
- President Scott asked for confirmation that Blue Shield was participating, along with other health plans, in a provider update of directories project. And, whether there was an intent to present the project to the Health Service Board. President Scott recalled a recent program sponsored by Blue Shield in which all members were automatically opted in and needed to opt out of participation, if preferable.
- Mr. Brown confirmed that considerable effort had already been undertaken regarding the project. He also verified that Blue Shield would return to present the details of the

provider directory and how members would be impacted.

- Commissioner Breslin asked if Blue Shield provided nutrition counseling as a member benefit.
- Mr. Brown stated that he would check to see if nutrition counseling was provided and get back to HSS staff.

Public comments: Claire Zvanski, RECCSF representative, stated surprise at Blue Shield's low rate increase. She again pointed out the high amount that early retirees with families are charged—nearly $2,000 per month, which is a $41 increase. She stated that sometimes the cost of living increase does not reach $41 per month. Increases for dependent coverage impacts early retirees the most. She asked that the rates for early retirees be kept as low as possible

Dennis Kruger, active and retired firefighters' representative, stated that he was glad to see Blue Shield change their methodology to an opt-in program rather than an opt-out, which caused problems the last time.

Barbara Hughes, retired MUNI employee, reported that she was notified by letter of the need to find a new cardiologist at Sutter Pacific.

President Scott asked Ms. Hughes to speak with Mitchell Griggs, HSS Chief Operating Officer, regarding her issue.

Director Dodd stated that she felt obligated to clarify that Blue Shield's plan is flex-funded and that the low rate was the result of the work of HSS since Blue Shield is not fully-funded. HSS pays the claims incurred by members and hospital bills directly.

Action: Motion was moved and seconded by the Board to accept Blue Shield's Flex-Funded non-Medicare rates and premium contributions for actives and early retirees for the 2017 plan year.

Motion passed 6-0.

□ Meeting Break Recess from 2:40 to 2:47 pm

□ 05122016-06 Action item

Approve UHC City Plan Employer Group Wavier Plan ("EGWP") rates to be included in Medicare retiree rates (Aon Hewitt)

Staff recommendation: Approve EGWP Medicare rates (pharmacy).

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

- Mr. Kochhar reported that the 2016 EGWP premium for City Plan is $171.09 per member per month ("PMPM").
- UnitedHealthcare proposed a 28% increase to the EGWP premium or $218.99 PMPM for 2017. The costs of the EGWP renewal are 100% experience-based. See pages 1 and 2 of report.
- Commissioner Follansbee asked whether all of the factors in the EGWP premium were part of a trend or should a 28% increase be expected again next year.
- Director Dodd stated that during the March meeting, HSS presented testimony submitted to CMS regarding the reductions in EGWP. Those reductions were not made to all plans.
- Ward Brigham, UnitedHealthcare Vice President and actuary, stated that the presentation was at a very high level, noting that the 28% increase was broken down into several pieces.
- Director Dodd stated that UHC's numbers passed last June were not high enough; however, to its credit, UHC did not build that loss into the rates this year.
- Mr. Ward confirmed that UHC stood by its numbers last year and would not seek to recoup funds. He stated that one of the issues being discussed is the shrinking reimbursement from CMS. The structure of EGWP payments for group plans will be changing and will be based on individual bids. He stated there was a constant battle between carriers and the government as the

government attempts to chip away at reimbursement.

- Commissioner Breslin moved to approve the Employer Group Waiver Plan.
- Commissioner Sass seconded the motion.

Public comments: None.

Action: Motion was moved and seconded by the Board to approve the UHC City Plan Employer Group Waiver Plan premium at $218.99 per member per month for the 2017 plan year.

Motion passed 6-0.

□ 05122016-07 Action item

Suspend Self-Funded Plans' Stabilization Policy and approve a one-time $5.55 million subsidy of UHC (City Plan) active and early retiree premium contributions for the 2017 plan year from the City Plan Stabilization Reserve (Aon Hewitt)

Staff recommendation: Approve one-time suspension of the Self-Funded Plans' Stabilization Policy and allocate a $5.55 million subsidy from the City Plan Stabilization Reserve for active and early retiree City Plan rates and premium contributions for the 2017 plan year.

Documents provided to Board prior to meeting: Health Service Board Self-Funded Plans' Stabilization Policy.

- Mr. Kochhar reported on actives and early retirees covered under City Plan.
- The contract size has increased since the historical low in December 2014 from 1.24 to 1.31 as of December 2015.
- The average incurred cost for actives per month is $1,486 versus the average premium of $1,232 per month. These amounts represent an incurred loss ratio of 121% for 2015.
- The average paid cost for actives per month is $1,462 versus the average premium of $1,232 per month. These amounts represent a paid loss ratio of 119% for 2015.
- Total enrollment for early retirees decreased during 2015.

- The average incurred cost for early retirees is $2,196 versus a premium of $1,468 per month. These amounts represent a loss ratio of 150% for 2015. A standard loss ratio would be 90%.
- The average paid cost for early retirees per month is $2,321 versus a premium of $1,468 per month. These amounts represent a paid loss ratio of 158% for 2015.
- In 2015, the Health Service Board approved the suspension of the self-funded stabilization reserve policy on a one-time basis, as well as spending additional claims stabilization funds to delay the implementation of the 2018 excise tax.
- If only one-third of the stabilization reserve was applied and no additional claims stabilization funds were allocated, the 2017 premium calculation for active employees and early retirees would be 45%.
- Allocating $5.55M from the self-funded stabilization reserve in plan year 2017 to the status quo premium would reduce the status quo rates for active employees and early retirees from 45% to 15%.
- Mr. Kochhar reported that $7,586,000 was in the stabilization reserve. He proposed Board approval one more time to apply $5.55M to lower the rates for active employees and early retirees.
- Mr. Kochhar also noted that the contingency reserve used to pay excess losses had a balance of $5,179,916. Those funds would not be used for the proposed buy-down.
- Commissioner Breslin asked if the $5M contingency reserve was just for UnitedHealthcare.
- Mr. Kochhar responded affirmatively.
- Commissioner Breslin asked about the number of people in City Plan, stating that it appeared there was a decrease.

- Mr. Kochhar stated that page 3 of the report indicated at the end of December 2015, there were 501 singles, 73 employees plus one and 38 employee plus two.
- Commissioner Breslin asked how many e-only premiums were picked up by the City. Those members would not have a hardship because the City pays 100%.
- Director Dodd stated that there were two issues involved. First, HSS would need to separate out those e-only City Plan members by union since SEIU 1021 members receive 100% pick up by the City. The City only pays up to the Blue Shield rate for all other members in City Plan, so they would have to pay the difference.
- Marina Coleridge, HSS Data Analytics Manager, reported that there was a gain of 71 active members in City Plan and a gain of approximately 30 early retirees in 2015. She was unable to say how many e-only members received full pick up by the City as negotiated by MOU. However, she noted that there were very few employees taking advantage of the 100-96-83 contribution strategy.
- Commissioner Breslin expressed concern at leaving approximately $2M in the stabilization reserve, and asked what to expect next year.
- Mr. Kochhar responded that the experience of the plan would determine whether a surplus or deficit would be generated next year.
- Commissioner Sass also expressed concern regarding $2M remaining the stabilization reserve if the Board were to approve the $5.55M buy-down. Because of the change in EGWP, Medicare retirees will see higher rates next year but will have no offset from the stabilization reserve. He asked if the stabilization reserve could be allocated to all members.
- Director Dodd stated that Medicare retirees would receive two subsidies under EGWP.

- Mr. Kochhar directed Commissioner Sass to page 20 of the report (2017 City Plan Monthly Rate Card) under "Retiree with Medicare," which indicated the monthly rate of $362.85.
- Commissioner Breslin again expressed concern for Medicare retirees with families.
- Commissioner Sass suggested allocating 50%of the stabilization reserve this year, leaving 50% for next year instead of $2M. This would allow at least two years of available stabilization reserves.
- Commissioner Lim stated that the purpose of allocating the stabilization reserve was to reduce the rates in order to prevent member migration.
- President Scott stated that the issue at the center of the discussion was if the Board approved the buy-down, whether the capacity for similar action would be available next year.
- Director Dodd reminded everyone that the topic of discussion was the stabilization reserve and not the contingency reserve.
- Commissioner Sass again expressed concern for potential high rate increases next year.
- Director Dodd stated that with only six months of utilization available, it was difficult to determine next year's rates,
- Commissioner Follansbee asked whether HSS should prepare members for future potential large rate increases due to the stabilization reserve when publishing the 2017 rates in the open enrollment guides.
- Commissioner Sass moved to allocate 50% of the remaining stabilization reserve to buy-down the active and early retiree City Plan rates and premium contributions for the 2017 plan year, thereby leaving 50% available for the 2018 plan year.
- Commissioner Breslin seconded the motion.

- Commissioner Lim expressed extreme concern regarding reducing the stabilization reserve amount below the proposed $5.55M amount due to potential migration and possibly the death of City Plan.
- Mr. Kochhar stated that the proposal was made to keep City Plan viable as long as possible.
- Commissioner Lim stated that City Plan's increase in membership for 2016 was due to last year's buy-down. Had the Board not taken that action, this year's membership could have been much lower due to migration.

Public comments: Claire Zvanski, RECCSS representative, stated that first and foremost, HSS has always been in business with its own plan and that the Board's first responsibility is to City Plan. It was originally established in the Charter that City employees were to receive the best benefits, thereby the creation of City Plan. The HMOs were added as a convenience for members and lower cost options, as well as the dental plans. Ms. Zvanski stated the reserves should be handled at the Board's discretion; however, the first consideration should be to keep the City Health Plan at a competitive rate against all others and to grow or at least sustain it.

Action#1: Motion was moved and seconded by the Board to allocate 50% of the remaining stabilization reserve to buy-down the active and early retiree City Plan rates and premium contributions for the 2017 plan year, thereby leaving 50% available for the 2018 plan year.

Motion passed 4-2

Commissioners Scott, Breslin, Farrell and Sass voted in favor of the motion.

Commissioners Lim and Follansbee dissented.

President Scott instructed the actuary to bring the new rate calculations to the next meeting.

- Commissioner Follansbee moved to suspend the Stabilization Policy.
- Commissioner Breslin seconded the motion.

Action#2: Motion was moved and seconded by the Board to suspend the Stabilization Policy.

Motion passed 6-0.

□ 05122016-08 Action item

Presentation of UHC (City Plan) self-insured rates and premium contributions for actives and early retirees and preliminary Medicare retiree rate renewal for 2017 plan year (Aon Hewitt)

Staff recommendation: Approve UHC (City Plan) rates and premium contributions for actives and early retirees with a $5.55 million subsidy from the City Plan Stabilization Reserve and defer action on final 2017 Medicare retiree rates until June meeting.

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

See item 7 discussion.

Public comments: None.

Action: See item 7 action.

□ 05122016-09 Discussion item

Presentation of UHC (City Plan) National PPO ("NPPO") audit (Aon Hewitt)

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

- Dr. Paige Sipes-Metzler, Aon Hewitt representative, reported on the audit of UHC's National PPO plan conducted in February and March 2016.
- Ten percent (10%) of the membership was audited plus an additional 25 over sample of Medicare with dependents who were non-Medicare.
- Dr. Sipes-Metzler reported that there were no adverse audit findings. Three Medicare beneficiaries with differing numbers were reconciled by HSS and CMS. There were no programming issues.
- The UHC NPPO audit was clean and unqualified.
- Dr. Sipes-Metzler thanked UHC for its support during the audit.

Public comments: None,

□	05122016-10	Discussion item	Health Plans Dashboard – Early Retirees (Marina Coleridge)

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

- Marina Coleridge, HSS Data Analytics Manager, reported on the dashboard for early retirees prepared through the All Payers Claims Database and presented high-level comments.
- The report detailed inpatient, outpatient and pharmacy utilization and cost trends across Blue Shield, Kaiser Permanente, and City Plan for early retirees through Q3 2015.
- Ms. Coleridge also noted that risk scores for active and early retiree members were included in the Director's Report handouts. Risk scores were last presented to the Board in November 2014.

Public comments: None.

□	05122016-11	Discussion item	Presentation of Healthcare Value Initiative ("HVI"), which compares benefits across governmental and private sectors (Aon Hewitt)

Documents provided to Board prior to meeting: Report prepared by Aon Hewitt, "Health Value Initiative."

- Won Andersen, Aon Hewitt representative, presented Aon Hewitt's Health Value Initiative ("HVI").
- HSS pays the highest of member costs compared to other public sector industry.
- HSS members pay lower out-of-pocket costs compared to other public sector industry.
- HSS members pay lower premiums on average.
- Ms. Andersen reported that overall, HSS was at nearly 117% in efficiency and running its programs better than its competitors. The public sector had an approximate 105% efficiency rate.
- See report for all data comparisons.

Public comments: None.

REGULAR BOARD MEETING MATTERS

□ 05122016-13 Discussion item Director's Report (Director Dodd)

- HSS Personnel
- Operations, Data Analytics, Communications, Finance/Contracts, Wellness/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, Finance/Contracts, Wellness and Employee Assistance Program;
3. Revised Rates and Benefits calendar;
4. Report on Form 1095 costs.

- Catherine Dodd reported on her Director's Report, which may be viewed on the myhss.org website.
- Edward Tang, new HSS Benefits Analyst, was introduced. He previously worked in Social Security administration and at City College.
- Dana Lui, graphic artist reporting to Rosemary Passantino, also recently jointed HSS.
- The Governance Committee was updated on the rollout of the employee engagement survey on May 10, 2016. Committee Chair Breslin had also spoken with the principal of the firm conducting the survey, which will be distributed to HSS staff at the end of June.
- At the Board's request, a cost analysis of implementing the ACA's informational reporting on Forms 1094 and 1095 was conducted. The total cost in personnel time, software and postage was $136,927. Total employee hours were 1,867.

- Director Dodd's summary submitted to the State Legislative Committee on SB 932 was not heard at yesterday's meeting. Zuckerberg San Francisco General Hospital had objections to the bill. Director Dodd will be working with the author and the Pacific Business Group on Health (the sponsor) to gain the hospital's support.
- President Scott also noted the revised Rates and Benefits calendar in the handouts.

Public comments: None.

□ 05122016-14 Discussion item **HSS Financial Reporting as of March 31, 2016**
(Pamela Levin)

Documents provided to Board prior to meeting:

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

- Pamela Levin, HSS Deputy Director and Chief Operating Officer, reported on HSS financials as of March 31, 2016.
- The trust fund balance on June 30, 2015 was $81.5M. Based on activity through March 2016, the projected balance is $72.1M as of June 30, 2016.
- See memorandum and financial reports.

Public comments: None.

□ 05122016-15 Discussion item **Report on network and health plan issues (if any)**
(Respective plan representatives)

- Cindy Striegal, Kaiser Permanente representative, announced that Kaiser will be expanding to Santa Cruz County effective January 2017. Three new medical offices will open in Watsonville, Santa Cruz and Scotts Valley. Watsonville Community Hospital will be utilized for inpatient services.
- Paul Brown, Blue Shield representative, confirmed that nutritional counseling is covered as any other office visit.

- Director Dodd clarified that a member cannot self-refer to a nutritionist. It must be determined to be medically necessary.
- Shannon Haas, UnitedHealthcare representative, reported on metrics in the Medicare Advantage PPO plan:
    - From September 14 through December 31, 2015, 753 pre-enrollment calls were received and answered within five seconds with only two abandoned calls.
    - October 2015 had the highest volume of calls at 480.
    - During the period January 15 through April 5, 1,824 inquiries had been received by the call center.
    - The top five calls were related to validating benefits, updating contact information, seeking provider information, formulary questions and claims-related issues.
- Director Dodd stated that HSS had not received any complaints regarding UHC's new National PPO plan.

Public comments: None.

□ 05122016-16 Discussion item Opportunity to place items on future agendas

Public comments: None.

□ 05122016-17 Discussion item Opportunity for the public to comment on any matters within the Board's jurisdiction

Public comments: None.

□ Adjourn: 4:34 pm

Summary of Health Service Board Rules Regarding Public Comment

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

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

Disability Access

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

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

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

Knowing Your Rights Under the Sunshine Ordinance

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

Lobbyist Registration and Reporting Requirements

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

Summary of Health Service Board Rules Regarding Cell Phones and Pagers

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

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

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