FIVE YEAR PLAN
FY 2013/14–FY 2018/19

Prepared by the Health Service System management team at the request of the Mayor of the City & County of San Francisco
Mission Statement

The Health Service System of the City & County of San Francisco is dedicated to preserving and improving sustainable, quality health benefits and to enhancing the well-being of employees, retirees and their families.

Health Service System Customers

INTERNAL CUSTOMERS

- The Health Service Board
- Members of the Health Service System (employees and retirees of the City & County of San Francisco, the San Francisco Unified School District, the San Francisco Community College District and the San Francisco Superior Court)
- The Health Service Board
- Mayor, City & County of San Francisco
- San Francisco Board of Supervisors

EXTERNAL CUSTOMERS

- Employers served by the Health Service System (the City & County of San Francisco, the San Francisco Unified School District, the San Francisco Community College District and the San Francisco Superior Court)
- Taxpayers of the City & County of San Francisco
- Union leaders
Five Year Policy Goals

SUSTAINABLE, AFFORDABLE BENEFITS
In a climate of rapid change in the healthcare industry, the Health Service System will be innovative and pro-active in identifying and implementing the best options for driving down health premium costs while maintaining quality care.

REGULATORY COMPLIANCE
The Health Service System will operate in compliance with federal, state and local laws and engage in contracts with vendors that have appropriate resources and processes in place to ensure regulatory compliance.

DATA-DRIVEN DECISION MAKING
The Health Service System will build the capability for data-rich analytics and forecasting, to enable intelligent innovation and pro-active decision-making.

DEPARTMENT AND OPERATIONAL EXCELLENCE
The Health Service System will maintain and seek to exceed industry standards and continuously improve processes and work product in operations, finance, member services, communications, administration and information technology.

Five Year Strategic Initiatives

SUSTAINABLE, AFFORDABLE BENEFITS
- Identify opportunities, risks and best options regarding HSS response to the state, public and private healthcare exchanges that will launch beginning in 2014.
- Assess opportunities and risks to determine the feasibility of developing a health insurance purchasing exchange in coordination with other counties and public employers.
- Assess opportunities and risks to determine the feasibility of implementing an HSS HMO.
- Continue collaborating with network providers to improve quality of care and reduce total premium costs via Accountable Care Organizations and other provider network management strategies.
- Actively seek opportunities to manage GASB unfunded liability for retiree healthcare costs without compromising quality of retiree benefits.
• Continue to engage City department leaders, and leadership at SFUSD, SFCCD and the Superior Court, in wellness opportunities and work with the City Controller on outcomes-based wellness benefit design.

• Develop and implement outcomes-based employee and retiree wellness initiative.

• Improve, maintain and continuously improve vendor performance guarantees with effective financial penalties.

• Develop effective strategy for shielding HSS from the federal healthcare reform (“Cadillac”) excise tax on employer-sponsored benefits exceeding certain dollar thresholds, which takes effect in 2018.

• Develop and maintain a comprehensive voluntary benefits program at no cost to participating city employers.

REGULATORY COMPLIANCE
• To minimize risk of significant financial fines and penalties, develop comprehensive processes for maintaining compliance with federal, state and local law relating to employer-sponsored health benefits. This includes the Patient Protection and Affordable Care Act (PPACA), Health Insurance Portability and Accountability Act (HIPAA), Department of Labor (DOL) and Internal Revenue Service (IRS) regulations and California state health insurance mandates.

• Maintain comprehensive system of audits to support effective vendor management, transparent financial accounting and member adherence to HSS rules.

• Conduct ongoing training as required to ensure all staff are educated and informed about compliance issues and processes.

DATA-DRIVEN DECISION MAKING
• Invest in infrastructure and personnel required to develop the substantial healthcare reporting and analytics capabilities needed for effective rate negotiations, vendor management, premium cost analysis, monitoring of utilization trends, and management of the flex-funded HMO plan.

• Develop routine system of healthcare analytics reporting to all employers served by HSS.

• Actively seek opportunities to require provider cost and billing transparency.

• Invest in market benchmarking and monitoring of industry research and trends to ensure cost effective benefit design strategies.

• Invest in ongoing monitoring and analysis of individual and population health risks.

• Coordinate with City departments regarding Workers’ Compensation trends to better administer Long Term Disability benefits.

DEPARTMENT AND OPERATIONAL EXCELLENCE
• Continue to collaborate on successful implementation of eMerge.

• Meet performance targets in member service.
• Continue to collaborate with other departments and outside vendors on developing a plan for automating self-service benefits enrollment and premium payments.

• Continue to maintain and improve high quality accounting standards, including unqualified audits of the Health Service Trust.

• Continue to effectively inform and prepare the Health Service Board.

• Continue to seek better alignment between HSS and DHR regarding data analysis and cost projections relating to MOU health benefit negotiations.

• Participate in key health benefit industry professional organizations to stay current on industry trends and innovations.

• Enhance HSS website, digital media outreach and other communication programs to prepare for online enrollment, educate and engage HSS members, employers and unions about benefits, provider quality and costs, and promote wellness programs and other relevant information.

• Establish and maintain digital records system.

Health Service System Challenges

• To remain effective at minimizing premium costs while maintaining quality care, HSS must be proactive, agile and responsive. HSS staffing at the management, analytic and senior operations level is currently inadequate to meet the demands of the rapidly changing healthcare environment. Forecasting, probability modeling, predictive analysis and planning are critical elements for future success in managing over $750 million dollars spent annually on healthcare purchasing.

• As HSS continues to cope with problems resulting from the eMerge PeopleSoft 9.0 transition, there are insufficient resources to maintain day-to-day operations. This has resulted in significant overtime, service delays and member inconvenience.

• Health Service staff capabilities will need to be re-oriented to put substantially more emphasis on data reporting and analysis, regulatory compliance, vendor contract management and effectively coaching members on how to navigate a rapidly changing landscape of health insurance and wellness options. This will require substantial retraining of existing staff and recruiting of talent with new skill sets, as well as additional professional services. Additional office space will also be needed.

• Healthcare providers are likely to maintain a protectionist approach with regard to utilization data. Continued vendor opacity will inhibit HSS’ ability to effectively obtain the data necessary for analytics and forecasting. HSS must allocate resources to support contractual and legislative healthcare data transparency initiatives.

• As the industry shifts, employer or union groups may choose to migrate away from HSS plan to participate in health insurance exchanges. If the risk rating of the HSS member population goes up as a result, insurance premiums will become more costly for remaining members and employers.
• Tracking regulatory compliance requirements will become more complex as the federal healthcare reform regulations take effect over the next five years. HSS will need additional resources to continue tracking and ensure compliance.

• Member service response times and data entry efficiency rates have declined significantly due to the implementation of eMerge PeopleSoft 9.0 in August 2012. Significant resources and overtime are being dedicated to maintain basic operations, while staff is also documenting and resolving issues resulting from system programming oversights, errors and delays.
Anticipated Regulatory Changes

The following is a brief summary of some of the anticipated regulations that will affect HSS. Due to the volatility in the industry, it is likely there will be additional regulations and mandates that impact the administration of health benefits in the next five years.

<table>
<thead>
<tr>
<th>DESCRIPTION</th>
<th>TYPE</th>
<th>EFFECTIVE DATE</th>
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<tbody>
<tr>
<td>Healthcare FSA contributions capped at $2,500.</td>
<td>PPACA</td>
<td>2013</td>
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<tr>
<td>FICA and SECA additional payroll tax for high-income individuals.</td>
<td>PPACA</td>
<td>2013</td>
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<tr>
<td>Employer's deduction for Medicare Part D retiree drug subsidy becomes taxable.</td>
<td>PPACA</td>
<td>2013</td>
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<tr>
<td>Certify compliance with uniform standards and operating rules for electronic transactions that occur between providers and health plans that are governed under HIPAA, or face penalty.</td>
<td>PPACA</td>
<td>2013</td>
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<tr>
<td>Mandated coverage for qualified participation in clinical trials for life-threatening diseases.</td>
<td>PPACA</td>
<td>2014</td>
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<tr>
<td>Employers must offer affordable coverage to employees who work over 30 hours a week or face penalty.</td>
<td>PPACA</td>
<td>2014</td>
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<tr>
<td>Automatic medical plan enrollment for new employees</td>
<td>PPACA</td>
<td>2014</td>
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<tr>
<td>Large employers must offer coverage that is affordable and that meets the minimum value standards or face penalty.</td>
<td>PPACA</td>
<td>2014</td>
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<tr>
<td>Insurers must accept every employer that applies for coverage in the State where the insurer writes policies for health coverage and must renew/continue such coverage at the plan sponsor's option.</td>
<td>PPACA</td>
<td>2014</td>
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<td>State, public and private healthcare exchanges</td>
<td>PPACA</td>
<td>2014</td>
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<tr>
<td>Plans must have a minimum of 60% actuarial value and include certain &quot;essential benefits.&quot;</td>
<td>PPACA</td>
<td>2014</td>
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<td>No pre-existing condition exclusions for anyone.</td>
<td>PPACA</td>
<td>2014</td>
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<tr>
<td>Insurers and TPAs on behalf of group health plans must contribute a certain amount to the State reinsurance program each plan year between 1/1/2014 and 12/31/2016.</td>
<td>PPACA</td>
<td>2014</td>
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<tr>
<td>DESCRIPTION</td>
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<tr>
<td>Employer must report minimum essential coverage provided to IRS, or face penalty.</td>
<td>PPACA</td>
<td>2014</td>
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<tr>
<td>Employers with at least 50 full-time employees must report additional information regarding health plan to IRS, or face penalty (IRC §6055).</td>
<td>PPACA</td>
<td>2014</td>
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<tr>
<td>Fully insured plans offered must include the &quot;essential health benefits package&quot;.</td>
<td>PPACA</td>
<td>2014</td>
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<td>No eligibility waiting periods of more than 90 days.</td>
<td>PPACA</td>
<td>2014</td>
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<td>Increases the maximum incentive amount for wellness programs from 20% to 30% of the COBRA cost of coverage, with possibility of HHS increasing the cap to 50%.</td>
<td>PPACA</td>
<td>2014</td>
</tr>
<tr>
<td>40% excise tax on the value of coverage exceeding $10,200 for individual coverage and $27,500 for family coverage ($11,800 and $30,950 for retirees and employees in high-risk jobs) to be indexed annually. (Employer must calculate tax.)</td>
<td>PPACA</td>
<td>2018</td>
</tr>
<tr>
<td>Requires states to establish laws mandating that hospitals publicly disclose cost of inpatient and outpatient services and requires insurers to provide enrollees with estimated out-of-pocket costs for healthcare services.</td>
<td>HR 5800 US Congress; pending</td>
<td>Introduced 2012</td>
</tr>
<tr>
<td>US Supreme Court may hear case challenging Defense of Marriage Act, which could affect federal tax levied on healthcare benefits for same sex spouses and domestic partners.</td>
<td>Pending</td>
<td>TBD</td>
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### CALIFORNIA

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<tr>
<th>DESCRIPTION</th>
<th>TYPE</th>
<th>EFFECTIVE DATE</th>
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<tbody>
<tr>
<td>Prohibits gag clauses in contracts between health plans and hospitals that prevent plans from disclosing hospital cost and quality information to their members.</td>
<td>SB 751</td>
<td>Contracts issued after 2012</td>
</tr>
<tr>
<td>Bans gag clauses in plan-provider contracts that prohibit plans from sharing claims information with qualified health care reporting entities that would use the data to produce reports comparing providers on cost and quality.</td>
<td>SB 1196</td>
<td>Introduced 2013</td>
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<td></td>
<td>CA Legislature; pending</td>
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<tr>
<td>State healthcare exchange launches</td>
<td>PPACA</td>
<td>10/2013</td>
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<tr>
<td>Provides lifetime COBRA coverage option for some SFUSD and SFCCD retirees and eligible dependents.</td>
<td>AB528</td>
<td>In effect</td>
</tr>
<tr>
<td>US Supreme Court may hear appeal of lower court decision overturning Proposition 8 ban of same-sex marriage in California. If same-sex marriage becomes legal, eligibility for HSS domestic partners could be reconsidered.</td>
<td>Pending</td>
<td>TBD</td>
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### CITY & COUNTY OF SAN FRANCISCO

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<tr>
<td>HSS to determine credited service for employees hired on or after January 10, 2009, to determine eligibility and contribution levels for retiree health benefits.</td>
<td>Charter A8.428</td>
<td>2008; first employees hired under this provision may reach 5 years of service in 2013.</td>
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<tr>
<td>Change in composition of the Health Service Board.</td>
<td>Charter A8.432</td>
<td>Board composition to change in 2013</td>
</tr>
<tr>
<td>Change in vote required for Health Service Board to approve health plans.</td>
<td>Charter A8.432</td>
<td>2013</td>
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Anticipated Efficiency Improvements

With sufficient budget and staffing, HSS anticipates the following efficiency improvements over the next five years:

- Advances in analytics to more effectively manage health care vendor performance.
- Advances in processes regarding contracting, auditing, compliance and vendor management.
- Enhanced digital member communications, especially to facilitate self-service premium payments and online enrollments.
- Use technology to improve member service response times, including HIPAA-compliant electronic communications with members.
- Paperless member benefits records, in accordance with federal and state privacy regulations.

Anticipated Service Level Changes

Due to the uncertainty of the healthcare business climate, service level trends will experience some volatility.

If plan membership numbers remain stable, HSS anticipates additional service requirements due to the need for enhanced analytics to competitively manage contracted plans, as well as managing compliance in a complex and volatile regulatory environment.

If HSS moves forward with participating in a statewide municipal exchange, and/or instituting an HSS HMO, we anticipate expanding services to existing members, and/or participating in a larger pool of covered members.

If HSS loses a substantial number of enrolled members due to migration to health exchanges outside of HSS, we anticipate serving up to 20% fewer members. This is also likely to result in significantly higher health premiums for remaining members and their employers.

Major Variables Impacting Operations

- It is uncertain if HSS will have appropriate staffing and budget to transition to a more data-driven organization.
- HSS is almost wholly dependent on the Department of Technology for benefits administration infrastructure (eMerge PeopleSoft 9.0).
The implementation of PeopleSoft 9.0 currently requires the full-time attention of HSS’ two IT staff members. Consequently, other key operations functions and data queries are being neglected.

The composition of the Health Service Board, which oversees the Health Service System, will be changing in 2013. The impact of this change on HSS operations is uncertain.

Trends in hiring, retirements and layoffs affect the demographic composition of the HSS insured population.

Hospital and medical group consolidation in the Bay area may affect how effectively HSS and the Health Service Board can continue to negotiate premium rates lower than surrounding counties.

Recent Improvements

Effectively managed premium costs to beat industry trends, with total HSS premium increases ranging between 1.4% and 3% over the past three years.

- Successfully balanced Kaiser and Blue Shield risk pools and created competition to hold down pricing.
- Developed actuarial model tool to predict impact of premium contribution changes on risk, migration and cost trends.
- Established and implemented two successful Accountable Care Organizations which have improved quality of care from San Francisco-based doctors and hospitals, while reducing the Blue Shield premium cost trend from 9.05% to -3.25%.
- Improved life insurance and long term disability insurance plans through competitive RFP process, saving $2.5M annually.
- Pursuant to 2011 San Francisco Proposition C, HSS changed from a fiscal year to a calendar-year benefits period, favorably affecting the premium rating trend. This, in combination with flex-funding of the Blue Shield HMO and co-pay changes, reduced Blue Shield premium rates nearly $47M across two years.
- Change to a calendar-year benefits period also allowed implementation of EGWP (Employer Group Waiver Plan) for Medicare pharmacy benefits, resulting in $2.3M annual premium savings applicable to GASB (Governmental Accounting Standards Board) reporting of retiree benefits liability.
- As a result of the change to a calendar-based plan year, HSS successfully implemented two Open Enrollments in one year, doubling the standard annual workload for finance, communications and operations staff. This was accomplished while transitioning to PeopleSoft 9.0.
Effectively complied with a significant number of new federal, state and local laws.

- Complied with all federal healthcare reform (PPACA) regulations to date, including expansion of preventive care coverage, elimination of lifetime coverage limits, coverage for dependents up to age 26, additional member mailings and W-2 reporting of the value of healthcare benefits.
- Complied with federal mental health parity law.
- Updated Section 125 Cafeteria Plan document, in accordance with IRS regulations.
- Complied with California state law mandating coverage of behavioral health treatment for autism spectrum disorders.
- Updated communications and operational processes relating to imputed income reporting and exemptions for same-sex spouses and domestic partners under federal and state law.
- Complied with the elements of the Proposition C, 2011 San Francisco ballot initiative, as applicable to date to the Health Service System and Health Service Board.

Effectively engaged and informed HSS members.

- Instituted digital and audio recordings of Health Service Board proceedings, available online.
- Launched four department wellness councils-MTA, Laguna-Honda, SFO and HSS. Improved availability of movement classes and stress reduction workshops City-wide.
Management Team

<table>
<thead>
<tr>
<th>CATHERINE DODD, PHD DIRECTOR</th>
<th>LISA GHOTBI, PHARM D COO</th>
<th>TRACEY LOVERIDGE CFO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tel 415-554-1703</td>
<td>Tel 415-554-0606</td>
<td>Tel [Telephone]</td>
</tr>
<tr>
<td>Fax 415-554-1752</td>
<td>Fax 415-554-1752</td>
<td>Fax 415-554-0650</td>
</tr>
<tr>
<td><a href="mailto:catherine.dodd@sfgov.org">catherine.dodd@sfgov.org</a></td>
<td><a href="mailto:lisa.ghotbi@sfgov.org">lisa.ghotbi@sfgov.org</a></td>
<td><a href="mailto:tracey.loveridge@sfgov.org">tracey.loveridge@sfgov.org</a></td>
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</table>

Department Contact Information

Health Service System
City & County of San Francisco
Tel 415-554-1750
Fax 415-554-1752
myhss.org
Medically Plans

$700M Trust Fund Contributions 2011 Health Service System

To choose healthy lifestyles.

City & County of San Francisco

Sustainable Benefits

Accountable Care
a. Contract for coordinated care, quality, efficiency
b. Foster Accountable Care Organizations
c. Collaboratively track data to ensure success

Data Transparency
a. Electronic medical records
b. Flex-fund HMO for access to claims data
c. Patient-accessible quality/cost information

Employee/Retiree Wellness
a. Risk scores based on clinical data
b. Wellness incentives
c. Patient engagement

Funding and Governance

$728M Trust Fund Contributions FY11-12

City & County of San Francisco

Health Service System FY11-12

Health Service Board
7 Commissioners:
4 Elected Members
2 Mayoral Appointees
1 City Supervisor

28 Plans From 10 Vendors
Medical: 6 HMO; 4 PPO
Dental: 2 DMO; 2 DPO
Vision: 1
FSA: 2

Health Service Staff

Operations
10,000 annual enrollment transactions
53,000 annual member interactions

Finance
12,500 annual financial transactions
2,740 annual rate calculations

Administration
24 annual public meetings

Communications
65,000 open enrollment packets mailed
53,000 website visits

Health Plan Vendors

Medical Plan Enrollment
FY11-12

50% Kaiser
54,308 enrollees

41% Blue Shield
44,384 enrollees

9% UnitedHealthCare
9,335 enrollees

Health Premium Costs
By Vendor FY 11-12

Pharmacy 48%
Hospital Inpatient 34%
Doctor Visit Outpatient 18%

Kaiser
$282.6M

Blue Shield
$275.6M

UnitedHealthCare
$65.5M

Dental and Vision
Delta Dental: $52.8M
Pacific Union Dental: $0.4M
Vision Service Plan: $4.3M

Other
WageWorks (FSA, COBRA): $6.6M
UNUM (LTD): $8.2M
ING (Group Life): $0.1M
EBS (Flex Credits): $5.0M

Year-Over-Year Health Premium Benchmarking

HSS Premiums: +2.4% +9% +13% +3.1% +1.2%
CA Premiums +8.3% +7.5% +8.1% +8.1% +8%
NIl Premiums +5% +5% +3% +3% +4%
NII Inflation +4% +2% +2% +3% +2%

Sustainable Benefits

Accountable Care
Data Transparency
Employee/Retiree Wellness

a. Contract for coordinated care, quality, efficiency
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