City and County of San Francisco

OFFICE OF THE CONTROLLER
CITY SERVICES AUDITOR

Health Service System:

The System is Not Structured, Governed or Managed Effectively to Ensure Equitable and Cost-Effective Health Benefits for All Members and Their Employers

Audit Number 04002P **June 29, 2005**

CITY AND COUNTY OF SAN FRANCISCO
OFFICE OF THE CONTROLLER

Ed Harrington
Controller

Monique Zmuda
Deputy Controller

June 29, 2005 Report Number 04002P

Bart Duncan
Director, Health Service System
1145 Market Street, 2nd Floor
San Francisco, California 94103

Scott Heldfond
President, Health Service Board
One Maritime Plaza, Suite 1600
San Francisco, California 94111

Dear Mr. Duncan and Mr. Heldfond:

The Controller's Office, City Services Auditor, presents its audit report concerning governance of the Health Service System (HSS). The audit objectives were three-fold: (1) to assess the extent to which the annual rate-setting process has resulted in obtaining affordable and cost-effective health care benefits for its members; 2) to evaluate the appropriateness and management of the Trust Fund balance (net assets available for health benefits) considering the purposes of HSS; and (3) to review best practices in public employee health benefit programs and whether HSS management and governance policies are consistent with current industry standards. The major audit findings include:

- The annual process to design health care benefits for employees, retirees and their dependents does not result in rates and premiums that are accurate, cost-effective, and affordable. Despite an accumulating surplus in the HSS Trust Fund indicating that amounts collected for health care benefits exceeded costs and medical claims, the Health Service Board does not conduct sufficient and effective oversight of the contractors providing services to HSS.

- The Health Service Board does not sufficiently emphasize cost containment strategies, despite consistent increases in health care costs over the past several years. Over the last five years, the cost of health care benefits to employers and members has risen by 85 percent and 39 percent, respectively. We note that much of this increase is driven by the market itself, however, the Health Service Board can act to limit some cost impacts. In the eleven Board and Rates and Benefits Committee meetings we attended between November 2004 and March 2005, we observed very little discussion or focus on the containment of health care costs.

- The Charter-mandated method for setting employer health contributions has resulted in over $10 million in overpayments (i.e., gap dollars) to the Trust Fund since 2002. These excess payments are costly to employers and are partly responsible for the significant surplus in the Trust Fund.

- Overpayments from both members and employers have accumulated in the Trust Fund, such that as of June 30, 2004, net assets available for health benefits exceeded $41 million. Because the Board has not developed formal policies to address these excess monies, the surplus has become a management problem for the Board, with differing expectations debated among Board members, HSS members, and others.

- Reserve amounts in the Trust Fund are not based on a formal policy, have not been subjected to a regular and formal evaluation, and are not monitored throughout the year.

- The Board's meetings and decision-making processes focus on operational detail, with little participation from HSS staff. Without a definition of appropriate roles and responsibilities among Board members, staff and consultants, the Board has become involved in detailed decisions without the appropriate tools, such as staff analysis and recommendations, to carry out its responsibilities.

- HSS and the Board lack a long-term business plan or goals to guide activities and identify areas needing focus, planning or change. Such a plan is critical to help prioritize issues that HSS will face on an annual and multi-year basis, and is an important process for the newly independent status of HSS.

- Outdated Charter provisions that narrowly define the requirements for some appointed members affect the Board's ability to govern effectively. Specifically, the requirement that a medical doctor and a member of the Board of Supervisors serve should be made more flexible. Further, Charter requirements that restrict HSS from funding administrative costs through its rates are preventing needed improvements in technology, training, and professional management systems.

- From our research of best practices for fiduciary boards, surveys we conducted in California counties and other local and state municipalities throughout the United States, and interviews with experts in this field, we identified common elements for a well-functioning fiduciary board.

While these findings point to changes that are needed at the Health Service System, we also would like to emphasize that the management and the Board have made major improvements over the last three years. Health Service has an updated membership accounting system and has strengthened its internal controls and financial reporting, resulting in an annual financial audit from its external auditors for Fiscal Year 2003-04 that is free of material weaknesses.

In addition, HSS has transitioned the administration of claims processing for the City's self-insured health plan (City Plan) to a third-party administrator, which has greatly improved the efficiency of claims processing and service to the members.

This audit report provides the management and the Board of the Health Service System an opportunity to augment the recent improvements and is especially important given the recent changes in status to an independent City department, the election of a new Board member, and the appointment of a new HSS Director.

The overall audit conclusions are that improvements are needed in the governance of the Health Service System, including the Health Service Board's oversight of the annual rate-setting process, management of the Trust Fund, and monitoring of its contractors. In addition, HSS needs to better define appropriate roles and responsibilities among Board members, HSS staff and contractors, and adopt long-term business planning to guide its activities. Finally, changes are needed in Charter language that affects the Board and System's ability to function effectively. Improvements in these areas will ensure that health care benefits are provided at affordable and cost-effective rates, the Trust Fund is managed prudently and in accordance with HSS goals and industry standards, and HSS is well positioned to address significant long-term cost management and other health care policy issues.

The Department's response to the audit concurred with all of the recommendations and is attached as Appendix X of this report.

We acknowledge the assistance and cooperation provided to the audit staff by the Health Service System, the Department of Human Resources, and by the Health Service Board members. The Controller's Office will work with the department's management and the Board to follow up on the recommendations made in this report.

Respectfully submitted,

Ed Harrington
Controller

TABLE OF CONTENTS

EXECUTIVE SUMMARY

FINDINGS AND RECOMMENDATIONS

CHAPTER 1

OVERSIGHT OVER THE ANNUAL RATES AND BENEFITS PROCESS

The Health Service System's process to design health care benefits for employees, retirees and their dependents does not result in rates and premiums that are cost-effective and affordable.

The Health Service System (HSS) process to establish rates and premiums for health plans is not effective in designing health care plan benefits at affordable, cost-effective rates. Despite an accumulating surplus in the HSS Trust Fund (Trust Fund), indicating that amounts collected for health care benefits exceeded costs and medical claims, the Health Service Board (HSB, or the Board) does not conduct effective oversight or review of the health care vendors contracting with HSS, or the consultants responsible for calculating the health care rates. Specifically, the Board has never conducted a formal evaluation of the contractors doing business with HSS. The primary components of this evaluation would include a periodic review of the contractors' performance measures (which should be stipulated in their City contracts), and a reconciliation of the rates projected and the actual expenditures incurred for the self-insured health plan (known as "City Plan"). Further, there has been no comparison of the HSS health care benefits package and the premiums for these benefits with other similar organizations, either public or private, to confirm that the costing of the HSS health benefits reflects market rates. As a result, the Board cannot ensure that the rates are appropriate and the benefits available to City employees, retirees and dependents are serving them cost-effectively.

The audit recommends that the Board establish a rate-setting process that includes a thorough review (at least annually) of the consultants and health care vendors contracting with HSS. As is common in this industry, an annual (or more frequent) review of the rates established for City Plan should be compared with actual experience, and any variances fully explained. Additionally, a regular and ongoing process should be established to correlate the HSS annual rates and premiums with Board-identified standards to ensure that health care costs represent fair and marketable rates. For example, such standards could be developed or based on the methods and rates of CalPERS or other similar entities or organizations.

COST MANAGEMENT STRATEGIES

The Board does not emphasize cost containment strategies, even though health care costs have consistently increased by double-digit rates since 2000.

In the eleven HSB and Rates and Benefits Committee (Committee) meetings we attended during the 2005-06 rate-setting process, we observed very little discussion or focus on the containment of health care costs. Despite the fact that the costs of health care have increased significantly over the past five years, the rate-setting process emphasizes proposed health care benefits and options, with little or no consideration to the additional cost to the employee or employer. This contrasts with the process in other counties in California, in which the affordable or budgeted cost is assessed prior to approving and designing the corresponding health care benefits.

The audit recommends that the Board and HSS adopt a strategic plan for health care cost containment. This long-term plan should identify methods to reduce health care costs, and should be incorporated into the rate-setting process as a primary component in the decision-making and approval of health care benefits.

CHARTER MANDATED EMPLOYER PAYMENTS DO NOT REFLECT COSTS

The 10-County Survey requirement has resulted in consistent overpayments, contributing to the surplus in the Trust Fund.

The Charter requires that employers contribute to the Trust Fund, for all active single employees, an amount based on the average cost of employee health care in the ten most populous California counties. This is termed by HSS as the "10-County Survey." For the past three years, this average amount has been greater than the actual negotiated cost of health insurance for the majority of employees—those who are Kaiser Foundation Health Plan, Inc. enrollees and, in some years, those enrolled in the Blue Shield of California plan. These overpayments, termed by HSS as "gap dollars," have amounted to more than $10 million since 2002. These excess payments are costly to employers and are partly responsible for the surplus in the Trust Fund (as discussed below).

The audit recommends that the Board work with City leadership to place a Charter amendment before the voters that would establish employer contributions equal to the 10-County Survey average of the ten most populous counties, as stated in the Charter, or the cost of the health plan chosen by the member, whichever is less. The Charter amendment should also allow for the computation of the 10-County Survey to be an average formula with factors that most nearly resemble the actual average cost to comparable California counties. These changes would reduce employer costs, simplify the management of the Trust Fund, and strengthen the HSS's position in the health care market without increasing the premium costs paid by members.

ACCUMULATING TRUST FUND BALANCE

Overpayments from both members and employers have accumulated in the Trust Fund, which was not designed to be managed as an investment trust.

The HSS Trust Fund was designed to operate as a pay-as-you-go system, with contributions by members and employers coming in, and premium payments and medical claims going out to health care vendors and providers. However, as of June 30, 2004, the Trust Fund had accumulated a balance of net assets available for health care benefits exceeding $41 million. This balance results not from deliberate decisions or prudent fiscal management, but from overcharges—a combination of variances between the rates charged and the claims paid for City Plan, gap dollars, and overestimates for transgender benefits and administrative costs. The Board has not developed formal policies to address the excess monies in the Trust Fund. As a result, the Trust Fund surplus has become a management problem for the Board, with differing expectations hotly debated among Health Service Board members (HSB members, or commissioners), HSS members, and others regarding the appropriate use of this surplus and the Board's responsibility in managing it.

The audit recommends that the Board develop a formal policy regarding the Trust Fund, including the use of any surplus fund balance. This policy should provide for business planning for several years into the future, and include a range of scenarios to adopt a 'spend-down' of any excess funds. These policies should be widely communicated to avoid misunderstandings of the intention and purpose of the Trust Fund, and the oversight obligations of the Board. An improved process to establish and monitor health care rates (as discussed above) should reduce the accumulation of monies, so that the scale of this issue is substantially reduced over time.

RESERVES MANAGEMENT

Reserve amounts in the Trust Fund are not based on a formal written policy, have not been subjected to a regular and formal evaluation, and are not monitored throughout the year.

HSS maintains reserves to cover the estimated cost of its incurred but not reported claims (IBNR) for City Plan. An additional reserve for unanticipated emergencies has also been established. These reserves are appropriate for a self-insured plan. The IBNR reserve and additional reserve are based on actuarial calculations performed to estimate the cost and processing time of medical claims, and equaled $14.5 million and $6.3 million, respectively, for a total of $20.8 million as of June 30, 2004. There are no written, Board-approved documents that officially set the reserves to these levels, and HSB has not performed a review of the methodologies applied and the assumptions used in these calculations to determine whether the reserve levels are adequate or appropriate. Further, unlike other health plans such as CalPERS, HSB does not monitor the reserves on a regular basis throughout the

year. For example, the improvements to the claims processing HSS implemented at the beginning of the fiscal year could significantly impact the required monies to be set aside for these reserves. And yet, there has been no indication that the Board performed any review of the appropriateness of the Trust Fund reserve levels since this claims process has been changed. Our estimates indicate that these processing changes could reduce the need for reserves by nearly $5 million, resulting in surplus monies in the Trust Fund of the same amount. Without adequate monitoring and review, the Board cannot take the definitive actions necessary to address additional excess funds in the Trust Fund.

The audit recommends that the Board develop and approve a formal, written policy officially setting a target amount for reserves, including the methodology, and the actuarial assumptions applied. This policy should be reviewed on a regular basis, considering best practices and industry standards used for reserves of similar health care plans, and other factors and changes in the HSS operations that would affect it. The reserves should be monitored periodically during the year, so that required actions to reduce a Trust Fund surplus, or to adjust rates for shortfalls, can be taken as soon as possible. Further, disclosing the additional reserve to the HSS financial statements would clearly communicate the Board's intent and purpose in setting aside these funds.

CHAPTER 2

ROLES AND RESPONSIBILITIES OF BOARD, STAFF AND CONSULTANTS

The Board's meetings and decision-making processes focus on operational detail, with little participation from HSS staff. Consultants provide information and data without recommendations to the Board.

Without a framework to define appropriate roles and responsibilities among HSB members, staff and consultants, the Board has become involved in detailed decisions without the appropriate tools, such as staff analysis and recommendations, to carry out its responsibilities. This is most clearly evident in the rate-setting process. Although the role of this committee is to guide and provide oversight to the annual rate-setting process, much of the analysis and comparisons of benefit options—tasks typically assigned to staff—are performed by the Committee members themselves at each of the monthly meetings. As a result, this is an overly lengthy process, requiring nearly six months to complete. Health benefit topics were revisited three to five times during this period, and yet few, if any, decisions are made prior to the final meeting. This already lengthy process is exasperated by the submission of voluminous and complex documents from the actuarial consultant, Towers Perrin, with no recommendations for Board action. In many cases, HSS staff did not review these consultant reports prior to these meetings, and therefore could not provide the necessary recommendations to the Board. These inefficiencies in decision-making could be addressed through a regular self-evaluation process that would guide the Board in reflecting on and improving its effectiveness as a fiduciary body.

The audit recommends that the Board and senior staff conduct a thorough review of the roles and responsibilities currently distributed among Board officers, members and committees, senior HSS staff, and contractors (i.e., the actuary and health care vendors), considering those duties defined by the Charter, and additional duties necessary to provide effective management and oversight of HSS. The Board should prepare formal, written documentation of roles and responsibilities, distribute them to all relevant parties, and review them on a regular basis to ensure their continued relevance. Further, the Board should develop a self-evaluation process, whereby the HSB members monitor and report on its own performance. Such self-assessments have been determined to be a part of best practices for board governance. The Board may consider enlisting the assistance of consultants specializing in board governance, which has proved beneficial for other fiduciary boards, such as the San Francisco Employees' Retirement System (SFERS).

STRATEGIC PLANNING AND GOALS

A long-term strategic plan is critical to identify and prioritize issues that HSS will face on an annual and multi-year basis, and is an important process for the newly independent status of HSS.

The HSB lacks a business plan or goals that would guide its activities or identify areas needing focus, planning or change. The HSS is a multi-million dollar health care system, expending more than $400 million annually and providing benefits to over 100,000 members and their dependents. Over the last five years, the cost of health care benefits to employers and members has risen by 85 percent and 39 percent, respectively. And yet, the Board has not conducted a review of recent cost containment strategies to curb these continually increasing expenditures. Likewise, the HSB has devoted comparatively little time on important issues such as the Medicare Modernization Act and the proposed annual budget for HSS for the upcoming year.

The audit recommends that the Board develop and adopt a strategic plan focusing on issues and concerns affecting HSS over the next several years. Such a plan should include system-wide objectives and strategies for meeting these objectives, allowing for time frames and expected completion dates. Periodic reporting and evaluation of the Board's progress towards its goals, as well as regular updating, should be part of the strategic planning process.

CHARTER GOVERNANCE ISSUES

Outdated Charter provisions restrict the Board's ability to govern effectively and professionally.

The Charter establishes specifications for the appointment of certain HSB members, including that one Mayoral appointee must be a medical doctor and one must have expertise in the health care field; and that the Board of Supervisors must appoint one of its own members to the HSB. The Mayor's medical doctor appointment has been

vacant for nearly one year, which may be related to the difficulty in identifying an available individual with these narrowly defined qualifications. The commissioner appointed by the President of the Board of Supervisors attended infrequently throughout his term, and resigned in August 2004. This position has not been re-appointed.

The audit recommends that the Board work with City leadership to revise the Charter to expand the options for the Mayoral appointee who currently must be a doctor of medicine to include experience and expertise in clinical medicine (e.g., nurse, dietician, pharmacist). Also, the qualification requirements for the Mayoral appointee who must have experience in the health care field should be expanded to include health care benefits, insurance, finance, accounting, actuarial or business. Further, the Charter provisions should be modified so that the member appointed by the President of the Board of Supervisors need not be a current member of the Board of Supervisors, but should also have the knowledge and/or expertise in health care benefits, insurance, finance, accounting, actuarial or business.

CHARTER ADMINISTRATIVE FUNDING ISSUES

Charter requirements that restrict the Health Service System from funding administrative costs through its rates are preventing needed improvements in technology, training, and professional management systems.

The Charter states that the City must provide funds to administer the HSS, and together with other Charter provisions, this language has meant that the budget for HHS's staff, technology, and other administrative costs must be approved through the City's budget. Even though these costs are spread to City departments, this effectively means that the HSS is subject to limits affecting the City's General Fund; the Board has little ability to make budget plans; and HSS cannot spend Trust Fund dollars for Board training, improvements to its membership data system, professional advice, and other elements that are important to the professional management of HSS. This is contrary to the funding of such functions by other fiduciary boards. For instance, SFERS funds the training of board members through its Trust Fund, thereby allowing for the budgeting of this important educational requirement on an annual basis.

The audit recommends that the Board work with City leadership to revise the Charter to allow for a broader range of eligible administrative expenditures from the Trust Fund, including upgrades to and ongoing maintenance of HSS information technology systems and costs related to the education and training of HSB members. The Charter revisions should allow these costs to be built into a rate structure that would appropriately spread costs to City departments and to members and be part of the overall budgeting and cost management process.

CHAPTER 3

BEST PRACTICES FOR AN EFFECTIVE FIDUCIARY BOARD

From our research of best practices for fiduciary boards, the surveys we conducted in California counties and other local and state municipalities throughout the United States, and interviews with experts in this field, we identified certain common elements for a well-functioning fiduciary board. These are fully explained in Chapter 3, and are summarized as follows:

- Role Clarity. The board should be focused on broad, long-term policy and business planning; the staff should concentrate on the day-to-day operations of the organization. This allows for an appropriate segregation of duties; defined responsibilities for board, staff and consultants; and clear expectations and lines of accountability for all parties.

- Policies and Procedures. Such policies provide boards with guidance in their functions and activities, including codes of conduct, education and training, and communications with stakeholders and others.

- Strategic Planning. Through this planning, the board, Director, and staff can establish a mutual understanding of the common goals, and the appropriate prioritization of the needs and opportunities of HSS.

- Education and Training. All HSB members must have the opportunity to obtain knowledge specific to the health care industry, and on topics of concern to HSS, so that they can make the critical decisions and develop strategic policies that will have a lasting impact on HSS.

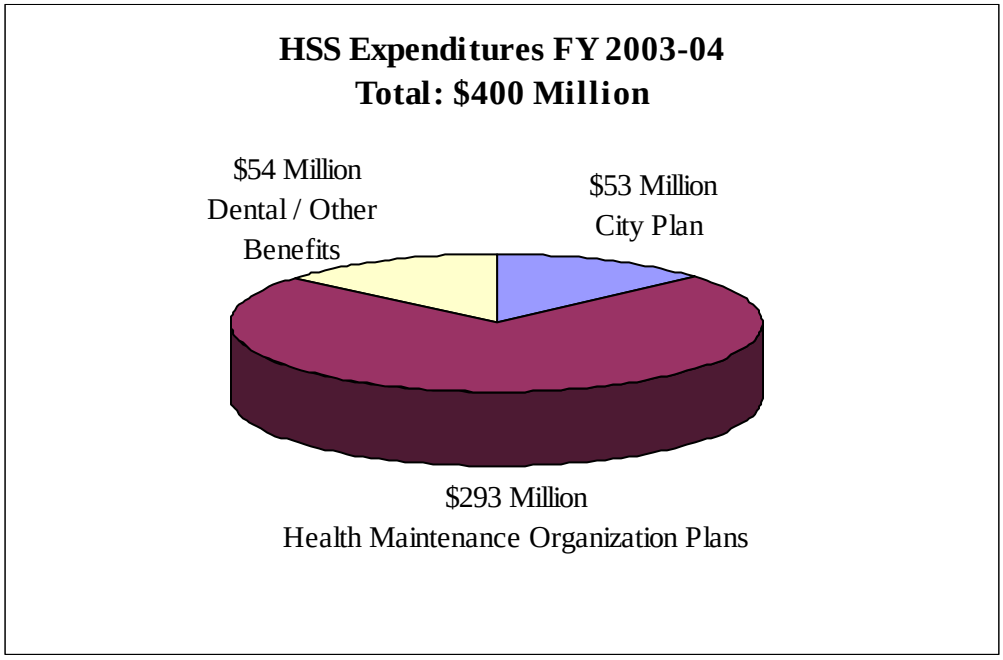
- Communications. Strategic communications, directed toward constituents and other stakeholders on a timely basis, is a key management tool to avoid misunderstandings, and promote good working relationships among all parties.

- Contractor Selection and Performance Review. The development of formal guidelines for contractor selection and review will ensure that the process is efficient, diligent and equitable, and that competitively priced services are obtained for HSS.

INTRODUCTION

In fulfilling the mission of the Office of the Controller to promote efficient, effective, and accountable government within the City and County of San Francisco (City), the Controller's City Services Auditor conducted a performance audit of the Health Service System (HSS). HSS is responsible for administering the City's health service system, which offers medical and dental benefits to employees, retirees and their dependents of the City, Community College District (CCD) and the San Francisco Unified School District (SFUSD). HSS is currently transitioning from a division of the Department of Human Resources and will finalize its first budgetary process as an independent department effective July 1, 2005. HSS is governed by a Health Service Board (HSB, or the Board), which is charged with making rules and regulations for HSS administration, and has responsibility for obtaining and disseminating information to members regarding plan benefits and costs. In FY 2003-04, HSS spent $400 million on health care coverage for over 100,000 members and their dependents.

Figure 1



AUDIT SCOPE & OBJECTIVES

The current performance audit of the HSS covered the HSB-led process of designing health care benefits and determining the rates for these benefits, as paid by members and their employers, and the impact to the amounts paid by these parties, and to the surplus in the HSS Trust Fund (Trust Fund). Our audit covered the actions of the HSB and HSS during the period November 16, 2004 through March 10, 2005, which were specifically

related to the establishment of health care benefits and rates, reserves or 'spend-downs' of the Trust Fund, and any other policy or strategic issues or concerns of HSS. In order to understand the history and reasons for these critical decisions, we analyzed prior Board-approved actions and resolutions during the period January 2001 through the current rate-setting process, which ended in March 2005.

A performance audit includes obtaining an understanding of internal controls considered significant to the audit objectives and testing compliance with significant laws, regulations, and other compliance requirements. In order to plan our performance audit, we considered whether internal controls considered significant to the audit were properly designed and placed in operation. Our work on established management controls included reviewing policies and procedures, interviewing key personnel, and reviewing selected actions to observe controls in place. We obtained an understanding of management controls over program operations that HSS management had implemented to reasonable ensure that the program met its objectives.

Our testing of internal controls was focused only on the internal controls related to our audit objectives as stated below, and was not intended to form an opinion on the adequacy of internal controls overall, and we do not render such an opinion. Weaknesses noted in our testing are discussed in the results of this report.

We conducted the audit in accordance with generally accepted government auditing standards issued by the Comptroller General of the United States. Our audit included reviews of policies, procedures, and other auditing procedures we considered necessary in the circumstances.

The performance audit objective was to assess the effectiveness of HSS oversight and management functions in ensuring that members receive benefits at an equitable and reasonable cost. Our focus was three-fold: (1) to assess the extent to which the annual rate-setting process has resulted in obtaining health care benefits, which were cost-effective and affordable for its members; (2) to evaluate the appropriateness of the Trust Fund balance (net assets available for health care benefits), considering the objectives and goals of HSS; and (3) to review best practices in public employee health benefit programs and whether HSS management and governance policies were consistent with current industry standards. The transition of HSS into an independent department creates an opportunity to examine the overall governance and management of the system and, where improvement is needed, implement the recommendations of this audit report into the changing organizational structure.

METHODOLOGY

The performance audit involved a review of relevant City Charter (Charter) provisions, HSB and Rates and Benefits Committee (Committee) meeting minutes, HSS contracts with the actuarial consultant and health care vendors, audited financial statements of the HSS, and other pertinent documentation and historical records.

In addition, we developed two surveys to gather information regarding health benefits administration, governance, funding and coverage; and to identify industry practices in cost containment. One of these surveys was submitted to 12 counties and one city in the state of California. Another similar survey was sent to 80 state and local government entities throughout the United States.

Audit staff attended the following meetings:

- Five HSB regular meetings during the period November 16, 2004, to March 10, 2005;
- Seven HSB Committee meetings during the period November 16, 2004, to March 10, 2005;
- California Public Employees Retirement System (CalPERS) - Board of Administration's Committee on Benefits and Program Administration meeting, February 15, 2005;
- CalPERS Board of Administration meeting, February 16, 2005; and
- San Francisco Employees Retirement System (SFERS) Board meeting, December 14, 2004.

Audit staff also conducted multiple interviews with the following individuals:

- Current and former staff at HSS;
- Current staff at the Department of Human Resources;
- Current and former HSB members;
- Actuarial consultants;
- HSS's independent auditor;
- Deputy City Attorney assigned to advise the Board and HSS;
- Staff and board members from organizations with similar fiduciary boards;
- Health care benefits consultants and actuaries working in other counties;
- Active and retired HSS members representing the City, CCD and SFUSD; and
- Members of CCD and SFUSD management.

BACKGROUND

The Health Service System was established by a Charter amendment in 1937 to provide health coverage for City employees, retirees and their respective dependents, and for all teachers, employees and retirees of the board of education. In 1957, the Charter was amended to make HSS an independent City department, at which time the City began providing funds for administering the system. Other changes to the Charter since then have had an impact on the health care benefits to its members, and the manner in which the costs for these benefits are paid. These are as follows:

- 1973 – The employers' (CCSF, SFUSD, and CCD) contributions toward health care premiums, paid on behalf of their employees, were fixed by formula to be the average amount contributed by the 10 most populous counties in California. This is now referred to as the "10-County Survey" average.

- 1993 – The Department of Human Resources (DHR) was given authority and responsibility for the HSS, which became a division of DHR instead of an independent City department.

- 2000 – Passage of Proposition E. The employers' contributions toward retiree health care were increased to cover one-half of the retirees' premiums, and one-half of the premiums for the retirees' first dependent.

- 2004 – Passage of Proposition C. Previously, the HSB was composed of seven members, including three elected members and four appointees. The nonelected members were appointed as follows: two members appointed by the Mayor, one appointed by the President of the Board of Supervisors, and one appointed by the City Attorney or designated Deputy City Attorney. With the passage of this proposition, an additional elected seat replaced the City Attorney's appointee. Additionally, HSS was removed from the Department of Human Resources and returned to its former status as an independent City department.

Medical Plans

HSS currently sponsors four health plans. Three of these plans are offered by health maintenance organizations (HMOs): Blue Shield of California, Health Net, and Kaiser Foundation Health Plan, Inc. In addition, HSS sponsors the self-insured City Plan, which allows members freedom of choice among medical providers. Under the City Plan, the City is responsible for and takes on the risk of paying for all members' claims out of the Trust Fund.

Health care premiums are collected from employees each pay period. These monies are then matched with the employers' share of contributions, all of which are transmitted to the HMOs each month. Premiums collected for City Plan are maintained in the Trust Fund, from which medical claims are paid throughout the month. In addition, certain amounts from the Trust Fund are allocated for administrative expenditures of HSS, including the costs of the annual open enrollment. Any amounts in excess of premiums, medical claims, or administrative expenses become a part of the Trust Fund. The Board is responsible for the management of these funds for the benefit of all members of HSS.

Governance

Over the past several years, HSS and the Board have realized a number of achievements that have improved the oversight and management of an increasingly complex health care system. Most significantly, the management letter accompanying the 2003-04 external audit of the HSS Trust Fund contained no material weaknesses or reportable conditions—for the first time in the past ten years. This success is due to efforts to strengthen HSS's internal controls, including the establishment of a Budget and Finance Committee. The rate-setting process was also standardized with the creation of a Rates and Benefits Committee and the engagement of a team of professional actuarial consultants. More recently, the HSB approved the incorporation of transgender benefits into health plans for HSS members—a pioneering effort for a public employee health care system. Other

notable achievements include the implementation of an upgraded membership accounting system to track and monitor HSS members' data and information; the introduction of written contracts with health care vendors; and the transition of City Plan claims administration responsibilities to a third-party contractor, which has improved the efficiency of claims processing.

Currently, the HSB fulfills most of its responsibilities through the following three sub-committees:

Rates and Benefits. This committee provides the guidance for the annual process of selecting and designing health care benefits for HSS members, and determining the rates and premiums to be charged to members and employers for these benefits. This process begins each year in September, with regularly scheduled meetings each month. It generally concludes by the following February, at which time committee members prepare a recommendation to the HSB for the health care benefits and rates for the upcoming fiscal year (effective July 1). Once the HSB approves this package, it must be submitted to the Board of Supervisors by March 1 for final approval of the benefits and of the City's financial contribution to health care costs.

Budget and Finance. This committee is responsible for reviewing, making recommendations and reporting back to the full Board on matters relating to: the annual Trust Fund budget; collections of amounts past due to the Trust Fund; and all financial audits pertaining to HSS, including the annual audit of the Trust Fund. The Budget and Finance Committee has convened twice in the past two calendar years.

Rules. This committee was created in November 2004 and is responsible for developing HSS rules and regulations that are consistent with the City's Charter and its ordinances. According to the Charter, the HSB must have rules that are "clear, definite and complete and so that they can be readily administered…." This committee has met twice since its inception, and is currently updating the existing HSS Rules document to reflect recent legislative changes and other developments that impact HSS membership and coverage.

CHAPTER 1
THE RATE-SETTING STRUCTURE AND PROCESS IS NOT EFFECTIVE IN DESIGNING HEALTH CARE BENEFITS AT AFFORDABLE, COST-EFFECTIVE RATES

CHAPTER SUMMARY

The process to establish rates and premiums for health plans is not effective in designing health care benefits at affordable, cost-effective rates. Although the Health Service Board (HSB, or the Board) conducts limited reviews of vendors doing business with HSS, this evaluation process is not sufficient to provide assurance that these vendors are providing the Health Service System (HSS) the services as expected and required. Further the HSB has not sufficiently focused on cost constraints as an important aspect of the annual process to design health care benefits for HSS members. The ineffectiveness of this rate-setting process is also due to City and County of San Francisco (City) Charter (Charter) requirements that annual amounts to be contributed toward premiums for health care benefits be based on the average health care contributions of the ten largest California counties. For the past several years, this average contribution paid by employers (San Francisco School District (SFUSD), Community College District (CCD), and the City), on behalf of their employees has exceeded the actual cost in some cases. As a result, the Board cannot confirm that health care premiums and rates are cost-effective or affordable. Further, these excess contributions are partly responsible for the increasing balance in the HSS Trust Fund (Trust Fund). A significant surplus balance in the Trust Fund is not consistent with the purpose or intention of the HSS.

Beginning in September each year, the Board's Rates and Benefits Committee directs the process to design health care benefits and to establish the rates and premiums to be paid by members and employers for these benefits. This process is termed by HSS as the "rate-setting process." Historically, the rate-setting process has taken more than six months to complete, and has required the assistance of the actuary, Towers Perrin. The actuary's tasks in this lengthy process have included calculating the rates for the self-insured medical health plan (City Plan) and self-insured dental plans, and estimating the level of reserves to be set aside for these plans. They also lead the negotiations of health care premiums with the Health Maintenance Organization (HMO) plans—Blue Shield of California (Blue Shield), HealthNet, and Kaiser Foundation Health Plan, Inc. (Kaiser)—and for certain dental and vision plans. In addition, staff from Towers Perrin have coordinated with the HMO plans to provide detailed reports of the various benefit plan options to the Board as they are presented at the monthly meetings throughout this process.

The Health Service Board Needs to Improve its Oversight of Contractors to Ensure That Services Provided Are Appropriate and Cost Effective

Although fiduciary boards may delegate various tasks to management, staff and consultants, the board is still responsible for supervising those to whom it has delegated duties, using appropriate monitoring and evaluation processes. For many boards, this regular review process might include comparisons of contractor performance to peer groups, to similar organizations, to the standards included in the contracts, or to expected outcomes. Such comparisons provide a means of evaluating the performance of these service providers and their contributions to the organization.

Although Towers Perrin has contracted with the City since 2001, their work has never been formally reviewed. Their contract, as renewed each year since 2001, has allowed for evaluation and performance review—a function of good government. Nevertheless, no review of Towers Perrin has been performed.

Our discussions with other consultants and actuaries indicated that part of their regular year-end performance review for self-insured health plans includes an evaluation of the annually calculated plan rates. This evaluation and review involves a reconciliation of the differences between the calculated rates and actual medical claim expenditures. Significant variances are identified and assumptions are disclosed. In this way, improvements in the annual calculation process can be implemented, thereby assuring that cash outlays for medical premiums closely resemble the cost for the medical benefits purchased.

This type of analysis and review of the rates for City Plan has not been prepared and presented to the HSB, even though Towers Perrin's staff have told us that they have the data and the ability to do so. Such reconciliation would determine the extent of the variance between the rate projections and the actual medical claims made during the year. A further analysis could identify the reasons for these variances, including explicitly identifying the assumptions used, and thereby improve future rate projections for City Plan. In general, the actuary is responsible for performing this task. However, staff from Towers Perrin told us that they have not prepared or presented this analysis to the Board because they have not been requested to do so.

This lack of oversight and review of the City Plan rates is particularly troubling, considering the growing Trust Fund balance, which has increased from $34.7 million in 2001, to more than $41 million as of June 30, 2004. The HSB has recognized this anomaly and has taken deliberate steps to curb this increase, by subsidizing health care rates for all employee groups. Despite these efforts, the Trust Fund as continued to grow over the past three years.

In some part, this growth is the result of the overpayment of health care premiums for the Blue Shield and Kaiser health plans, termed "gap dollars" (which represent the difference between amounts collected from employers, as required by the Charter, and the actual cost of medical coverage; this is discussed further on p. 19).

Given this, the effect of variances in City Plan health care rates must be considered as an important factor in the consistent growth pattern of the Trust Fund. In 2004, members and employers contributed over $50 million toward City Plan health care rates. Clearly, notable differences from the actual expenditures for medical claims for City Plan over a period of time could have a significant impact on the Trust Fund. Without reconciling and thoroughly understanding the differences between the annually calculated rates and the actual claims, HSS cannot be assured that the rates were not overstated and that health care benefits have not been overpaid.

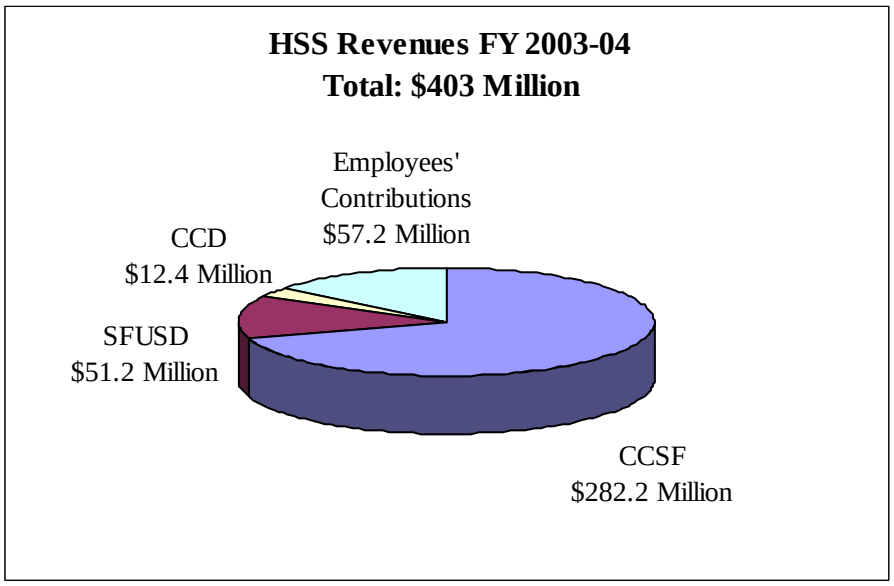
A consideration for the HSB in fulfilling its oversight responsibilities would be to commission a claims audit for City Plan, as a means of verifying the reliability of the payment data provided by the vendor. Such an audit would include reviewing the performance standards set forth in the contract, and verifying the accuracy and payment terms guarantees. Our research suggests that such audits are common in the health care industry, and often result in cost savings and an improvement in the employer's negotiating position during the rate renewal process.

Finally, although the representatives of the HMO plans have reported to the Board on an annual 'self-reporting' basis at certain meetings, an independent evaluation of the plans' guarantees at the outset of the 2004-05 rate-setting process was not conducted. Further, the HSB did not disclose how such performance records might have contributed to its decision to retain these health plans for the 2005-06 plan year.

The Health Service Board Needs to Better Address Cost Management Strategies

At the eleven full Board and Committee meetings we attended, we observed very little discussion of the budget or cost constraints. The few references to the budget generally were raised during presentations by a representative from the Mayor's Budget Office near the end of the rate-setting process. These presentations cited the City's fiscal challenges, and requested that Health Service Board members (HSB members, or commissioners) consider the impact of rates on the General Fund in their design and costing of the health plans. Employers contributing to HSS include the City, CCD and SFUSD; however, the City is by far the largest single contributor, paying $282 million in contributions for FY 2003-04 (82% of all employer contributions).

Figure 2



This is contrary to the process other California counties use in designing health care plans for their members. For example, in Alameda County, staff and consultants begin their annual rate-setting process with a formal review of the prior year's costs and performance data from the healthcare vendors. All parties (County staff, consultants and vendors) meet together to review this information and discuss potential plan design changes and cost containment strategies for the coming year. Likewise in San Diego County, staff and consultants hold a strategy session at least six months in advance of the rate renewal date to review utilization reports from the healthcare providers and to discuss goals and priorities for the coming year, including cost management. Health care plan options are then reviewed and analyzed in order to obtain the best benefits for the costs the employer and members can afford.

With sustained double-digit increases in medical premiums since 2000,[1] employers are searching for effective cost containment strategies. For instance, in addressing future retiree medical costs for Orange County (which will amount to more than $1 billion over the next 30 years), county managers are considering how much more employees will be contributing toward their own medical costs. Santa Clara County also recently extended its vesting period for retiree health care coverage from five years to eight years after assessing its ability to meet future obligations. Also of great concern is the decreasing level of benefits afforded retired employees. The 2004 Kaiser Family Foundation/Hewitt Survey on Retiree Health Benefits reported that 8% of employers had eliminated subsidized health benefits for future retirees in 2004, and 79% have increased retirees' contributions in the past year. And yet, there were no discussions from HSB members of specific strategies to address increasing health care costs and future obligations of retiree health care at the eleven meetings we attended.

[1] Source: Kaiser Family Foundation /Hewitt Survey on Retiree Health Benefits (2004)

Increasing retiree health care costs should be of particular interest to the City and the HSB following the passage of Proposition E in 2000, which increased the City's contribution to cover one-half of retirees' premiums and one-half of the premiums for the retirees' first dependent. In addition, San Francisco's five-year vesting period for post-retirement benefits falls on the short end of the five- to ten-year range we noted in our survey of other California counties. Four of the counties surveyed require at least eight years of service before employees vest. Medical coverage for City retirees far exceeds that of most other California counties we surveyed. For example, retired employees in San Joaquin and Ventura Counties must pay 100 percent of their own health care premiums. In addition, subsidized health care coverage does not extend to dependents of retirees in Alameda and Santa Clara Counties; and retiree health care is not a guaranteed benefit in either Sacramento or San Diego County.

The Charter Requires Employers to Pay Rates That Do Not Represent the True Cost of Medical Coverage

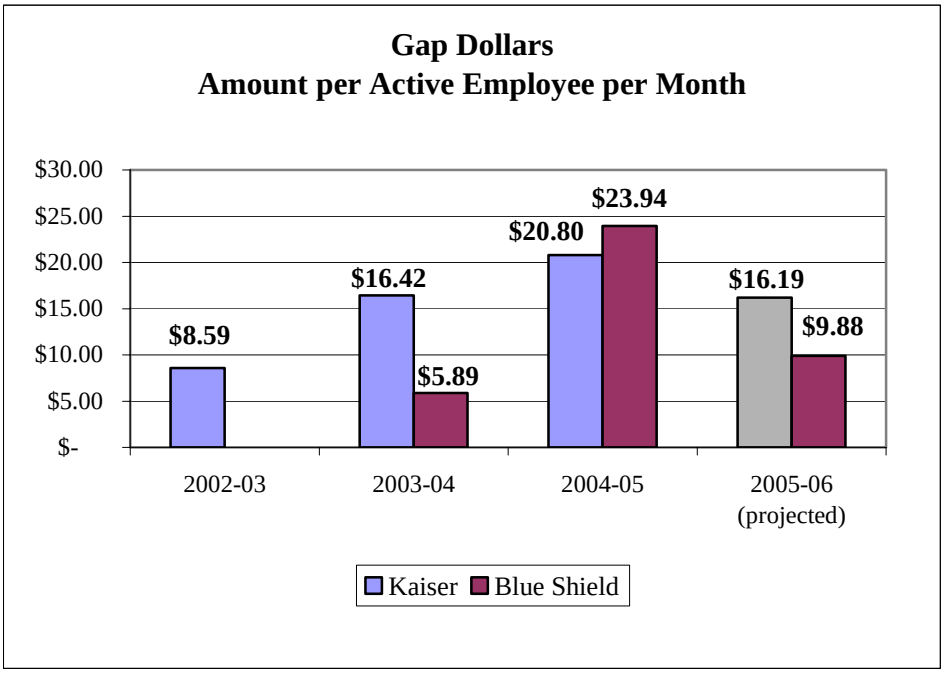
Charter section A8.423 requires the HSS to conduct an annual survey of health care premiums paid by the ten most populous counties in California, termed by HSS as the "10-County Survey." The overall average of health care premiums paid by these counties represents the basis for the employers' annual health care contribution for single, active employees. In other words, the employers must pay health care premiums based on those for employees of other regions in the state, and not necessarily on the rates negotiated with the HMO plans each year.

With the exception of Alameda County, none of the counties included in our survey was subject to a Charter requirement or legal ordinance that sets a minimum employer contribution toward employee health benefits. Alameda County's contribution is based on the lowest-cost plan sponsored by the county.

For the past several years, the negotiated premiums for Kaiser and Blue Shield were less than the Charter-required, 10-County Survey amount.[2] As a result, the premiums collected from employers on behalf of their employees enrolled in these two HMO plans exceeded the actual negotiated cost for these members. Overpayments generated by this Charter requirement, are termed by HSS as "gap dollars."

[2] For FY 2002-03, this overpayment relates only to the Kaiser plan, as overpayments were not applicable for the Blue Shield plan until FY 2003-04.

Figure 3



Number of Active Employees Where Gap Dollars Apply:

	2002-03	2003-04	2004-05	2005-06 (projected)
Kaiser	15,900	15,600	14,800	15,000
Blue Shield	N/A	4,000	4,900	5,000
Total	**15,900**	**19,600**	**19,700**	**20,000**

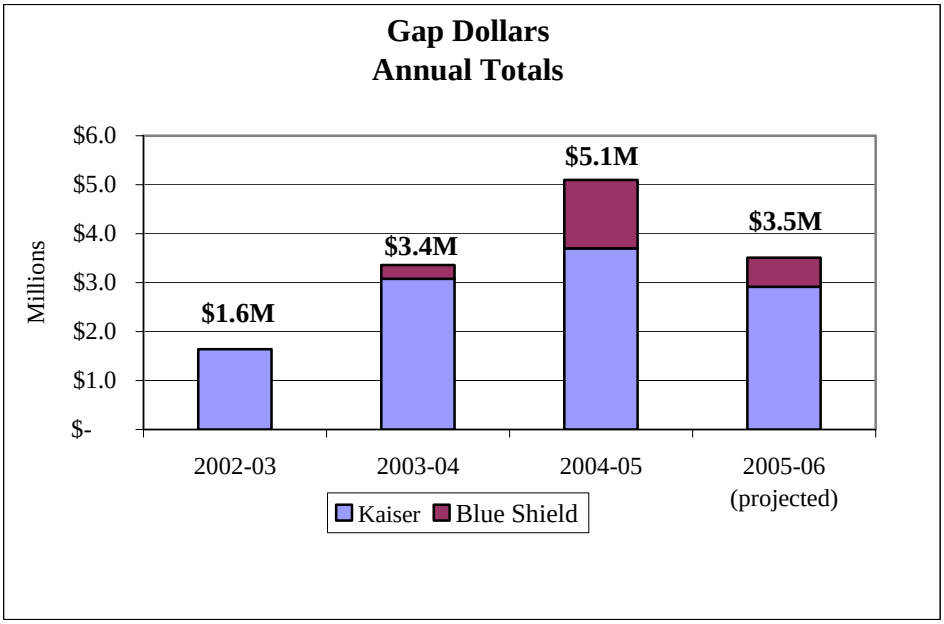
Further, because the 10-County Survey process is predetermined and commonly known among the health care vendors, the negotiating position of HSS is necessarily weakened. As a result, HSS and the Board cannot be assured that they are obtaining medical care benefits at the best market rates. Several years ago, Alameda County addressed a similar concern. On the advice of their benefits consultant, the county's Human Resources staff launched a successful effort to change the employer's baseline premium contribution from 100% of the Kaiser rate to that of the lowest-cost health plan selected by members. This markedly improved the county's position in annual rate renewal negotiations, creating greater incentives for its health care vendors to offer cost-effective rates.

The Board Has Attempted to Spend Down Accumulated Overpayments Since FY 2002-03

Over the past three years, gap dollars have accumulated to more than $10 million, and have contributed to the increasing surplus in the Trust Fund. Gap dollars for the Fiscal Year 2005-06 are projected to exceed $3 million. The HSB has acknowledged that these funds represent part of the excess monies in the Trust Fund, and has responded by authorizing a reduction, or 'spend-down,' to the Trust Fund each year since 2002. These

spend-downs have been used to decrease monthly premiums paid by employers and members.

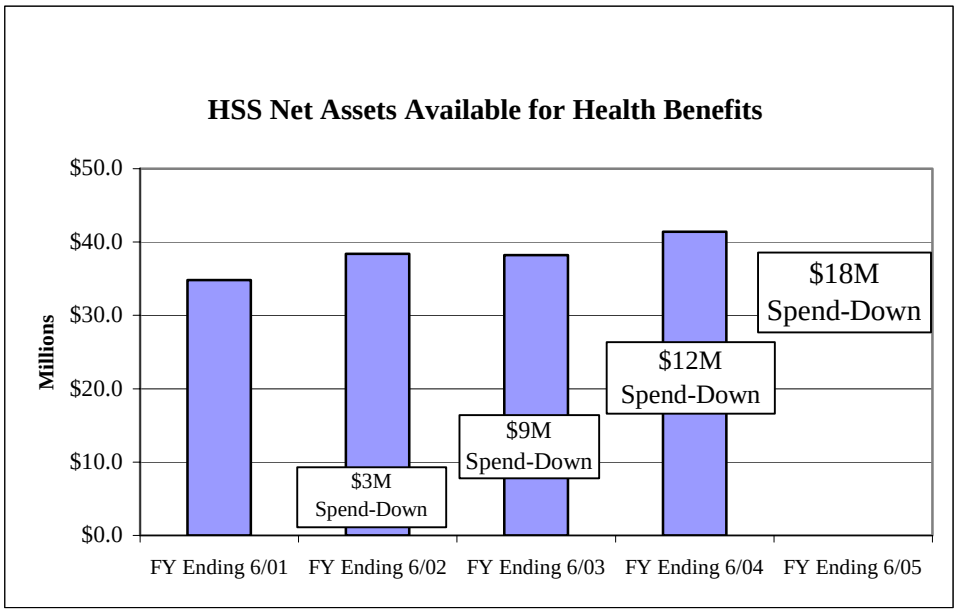
Figure 4



Premium reductions (or subsidies) approved by the HSB have been applied to all health plans, thereby benefiting all members. By far, most of these subsidies have been applied toward City Plan rates. To explain further, for the 2002-03 plan year, the HSB approved a spend-down of $3 million, all of which was allocated to reduce City Plan premiums. For 2003-04, the Board approved a $9 million subsidy, allotting $7.5 million to reduce City Plan premiums, and $1.5 million for subsidies among the three HMO plans. For 2004-05, the spend-down amounted to $12 million, three-fourths of which the HSB directed to City Plan, with only $3 million authorized to reduce HMO premiums. It should be noted that although HSS provides health care to more than 100,000 members and their dependents, City Plan members and their dependents have totaled no more than approximately 13,000—or 11 percent—of total HSS enrollment over the past four years.

Although these spend downs were intended to reduce the growing surplus in the Trust Fund, the balance has continued to increase throughout these years. In response, the HSB most recently authorized a spend-down of $18 million for FY 2005-06, directing $14 million to reduce City Plan rates, and the remaining $4 million toward HMO premiums.

Figure 5



Overpayments by the City Have Accumulated in the Health Trust Fund, Which Was Not Designed to Pre-Fund Future Liabilities

In addition to the accumulation of gap dollars and unexplained variances between City Plan rates and claims experience, certain administrative and transgender benefits fees have overestimated the actual costs associated with the fees collected from members and employers. The accrual of all of these overpayments has also contributed to the continued growth of the HSS Trust Fund since 2001. In addition, annual investment income is earned on HSS cash reserves, so that as the fund balance increases, more capital is available to realize earnings from this source. As a result, the Trust Fund's net assets available for health benefits exceeded $41 million as of June 30, 2004.

This balance represented the monies remaining in the Trust Fund after accounting for the required reserves to cover incurred but not reported (IBNR) claims for City Plan. IBNR accounts for medical claims for services that have occurred, but have not yet been submitted for reimbursement. Since City Plan is self-insured, IBNR reserves must be set aside each year to compensate for these claims. These reserves are intended to ensure HSS management that sufficient funds would be available to pay for any outstanding claims should City Plan be terminated unexpectedly. For the 2004-05 plan year, the actuary recommended an IBNR reserve of $14.5 million. That is, monies in the amount of $14.5 million were set aside so that HSS could meet all of its pending and projected obligations to City Plan members. The set-aside of a prudent level of IBNR reserves also complies with accounting and legal requirements, as well as sound governance practices for self-insured health plans.

It is important to note that the HSS Trust Fund operates as a "pay-as-you-go" fund, such that annual contributions from members and employers cover benefits for current active

and retired employees and their dependents. The Trust Fund was not established to pre-fund future retiree health care liabilities or to safeguard against future fiscal crises; if it were, the Board would need to hire professional investment managers to develop and implement strategies to sustain and grow the fund in perpetuity, similar to the SFERS Trust Fund. Instead, the HSS Trust Fund reserves are invested alongside those of all other City departments in the municipal investment pool managed by the Office of the Treasurer and Tax Collector.

Although the HSB has acknowledged that the Trust Fund balance is in excess of its management purposes (as evidenced by their definitive actions to spend down these excess funds over the past three years), they have not adopted any formal, written policies or rules regarding the Trust Fund and its reserves. Without clear guidelines, the Board has grappled with this issue every year, and has consistently delayed strategic discussions or actions relating to it. The reluctance of the Board to address the surplus and establish a formal reserves policy has fueled significant miscommunication and anxiety during the annual rate-setting process.

In effect, the Trust Fund has become a politically charged issue, instead of a standard financial matter to be managed objectively by an impartial fiduciary board. During our attendance at HSB meetings, we observed that the HSB members do not have a full or shared understanding of the nature of the Trust Fund, and some are clearly reluctant to participate in decisions regarding Trust Fund subsidies. For example, it has been suggested in HSB meetings that the offset of member health care premiums has the effect of subsidizing multi-million-dollar corporations, meaning the City's health care vendors such as Kaiser. In fact, the financial benefits of the premium subsidies authorized by the Board benefit HSS members and employers, and not the health plan vendors.

The Health Service Board Needs to Take Strategic Action to Better Manage and Monitor the Trust Fund and Its Reserves

This Trust Fund debate has allowed the Board to become mired in operational decision-making and has detracted from its primary responsibility to provide overall direction and oversight to HSS. The HSB should confine its actions to the development and periodic review of formal policies that define appropriate reserve levels, the methodology used to determine them, and strategies regarding the use of any surplus. These policies would ensure that the Trust Fund is managed by design, according to objective standards, instead of being subject to political forces. Instead of deliberating over detailed subsidy proposals each year, HSB members would rely on a set of standardized procedures for calculating an appropriate level of reserves, determining any Trust Fund subsidies, and monitoring the fund and its reserves on a regular basis.

Although Trust Fund reserves for self-funded health plans should be sufficient to cover expenses for IBNR claims, our survey of best practices in other California counties suggested that reserves should include an additional margin to cover unanticipated or catastrophic events (e.g., adverse claims experience or fiscal crises). For example, both San Joaquin and Santa Clara Counties set aside reserves above IBNR based on formal

recommendations by their actuaries, and track these reserves regularly. Over the past several years, Towers Perrin has calculated an additional reserve for the Board, and recommended in FY 2004-05 a reserve of $6.3 million above the $14.5 million in IBNR reserves. In total, target reserves for the Trust Fund were $20.8 million at June 30, 2004, although only the IBNR reserve is disclosed to the fund's financial statements. These reserve levels are equivalent to four months of medical claims, two-and-a-half months of dental claims, and one month of pharmaceutical claims.

While this level of total reserves has been presented in materials prepared by the actuary and mentioned by HSB members, there is no written, Board-approved document that officially sets the target at this level. In addition, our interviews of commissioners revealed that there was not a common understanding of or agreement on Towers Perrin's recommended target and its appropriateness. Some commissioners have also stated publicly that they would prefer a greater reserve level; however, they have not identified reasons or an established methodology to substantiate this preference.

In our research, we found that other counties typically rely on their actuarial consultants to calculate and recommend an appropriate level of reserves, which they review annually. For some counties, once this reserve is approved, a formal policy is written. Some employers also request a second opinion for the rates and reserves and use the services of another independent consultant to prepare this calculation. In this way, there is an assurance that the reserve level is commensurate and appropriate with the risks assumed.

The HSB has not formally reviewed Towers Perrin's recommended reserve level to confirm whether it is in line with the risk components of City Plan or industry standards. In addition, commissioners have not asked Towers Perrin or HSS staff to present updates on the status of the Trust Fund or its reserves on a routine basis.

Our analysis of City Plan medical claims history between August 2004 and January 2005 indicated that the Board should revisit its current reserve levels, and monitor its reserves more closely throughout the fiscal year. Over 85% of medical claims during that period were reimbursed within three months, well within the four-month estimate used as a basis for the calculating the reserves for City Plan. This quick turnaround in claims is the result of transferring this function from an in-house process to a third-party administrator, United Health Care (UHC), as of July 1, 2004. UHC has provided guarantees that most claims will be paid within ten business days. Since HSS's methodology of calculating reserves is largely based on the timing of the payment of claims, the reserve level should reflect this improved payment process. Using the most recent claims payment data, our evaluation indicated that total reserve levels could be reduced by nearly $5 million, resulting in total reserves ranging from $15 million to $17 million. As the required reserve levels are reduced, the excess monies in the Trust Fund correspondingly increase. Accordingly, we also estimate that surplus funds could range from $35 to more than $39 million. These levels of reserves and the surplus amounts in the Trust Fund must be compared to the total reserves of $20.8 million, and net assets available for health benefits of $41 million, as of June 30, 2004. As a part of their oversight duties, the HSB should discuss the current reserve methodology used by HSS with the actuary, taking into

account the assumptions used, and ensuring that the updated claims payment system is incorporated into this revised calculation.

Other reserve methodologies may more closely correspond to the risk factors of City Plan, and could likewise result in savings for the plan's members and employers. As the third largest purchaser of employee health benefits in the nation, and the largest in California, CalPERS is generally considered a driver of many trends in the industry. In May 2004, the CalPERS Board formally modified its reserving methodology for its self-insured health plans, utilizing the National Association of Insurance Commissioners' Risk-Based Capital (RBC) method.[3] The intention of the RBC methodology is to account for adverse claims experience—the costs of which could extend beyond the amounts collected in premiums. CalPERS staff acknowledged the value of the RBC methodology in providing a more explicit approach to assessing risks and the appropriate amounts that should be set aside to address those risks. Moving to this methodology resulted in a material reduction of reserve amounts for the CalPERS' self-insured health plans, which were previously based on a set projection equivalent to approximately four months of total claims.

The HSB has an obligation to submit fiscally sound health benefits and rates to the Board of Supervisors each year for approval. Disregarding the cost impact to members and employers, and to the City's General Fund, is not responsible. The multiple years of excess health care premiums have resulted in a growing Trust Fund, which was not the intention or purpose of this fund. These overpayments made over the past years have resulted in a Trust Fund exceeding $41 million at June 2004, representing monies that could have been used elsewhere for the benefit of the residents and employees of San Francisco. We acknowledge that the monies in the HSS Trust Fund are specifically designated for the benefit of members and their dependents of HSS. Nevertheless, it is helpful to understand the impact of the significant surplus in the Trust Fund, and the consequence of the overpayments of health care rates and premiums on other City services and programs. For instance, we reviewed pending FY 2004-05 budget reductions, based on the City's projected deficit. Currently, the projected deficit is $59 million for FY 2005-06.[4] In doing so, we determined that $525,000 is comparable to closing all recreation centers one day per week throughout the City from January through June. Further, nearly $800,000 is equivalent to the funding of projects in the Department of Public Works, relating to street cleaning, pothole repair, and additional citywide landscaping, all of which may be eliminated from the proposed budget for FY 2005-06[5] in order to meet statutory requirements for an annual balanced budget.

[3] To measure the amount of assets that are needed to provide medical care, the National Association of Insurance Commissioners (NAIC) developed formal Risk-Based Capital (RBC) requirements for insurance companies and HMOs. These requirements were developed based on an extensive study completed in 1998 and conducted by NAIC in connection with the American Academy of Actuaries.
[4] Source: *FY 2004-05 Nine-Month Budget Status Report*, issued by the Controller's Office on May 3, 2005.
[5] Source: *Mayor's FY 2004-05 Mid-Year Cuts* issued by the Controller's Office in December 2004.

RECOMMENDATIONS

1. Establish a rate-setting process that includes a thorough review (at least annually) of the performance of consultants and health care vendors contracting with HSS.

2. Establish an annual (or more frequent) review of City Plan rates, to be compared with actual experience, with any variances and assumptions fully explained.

3. Establish a regular and ongoing process to correlate the HSS annual rates and premiums with Board-identified standards to ensure that health care costs represent fair and marketable rates.

4. Adopt a strategic plan for health care cost containment. This long-term plan should identify methods to reduce health care costs, and should be incorporated into the rate-setting process as a primary component in the decision-making and approval of health care benefits.

5. Work with City leadership to place a Charter amendment before the voters that would establish employer contributions equal to the 10-County Survey average, based on the ten most populous counties as stated in Charter section A8.423, or the cost of the health plan chosen by the member, whichever is less. The Charter amendment should also allow for the computation of the 10-County Survey average to be an average formula with factors that most nearly resemble the actual average cost to comparable California counties.

6. Develop a formal policy regarding the Trust Fund including the use of any surplus fund balance. This policy should provide for business planning for several years into the future, and include a range of scenarios to adopt a spend-down of any excess funds. These policies should be widely communicated to avoid misunderstandings of the intention and purpose of the Trust Fund, and the oversight obligations of the Board.

7. Develop and approve a formal, written policy officially setting a target amount for reserves, including the methodology, and the actuarial assumptions applied. This policy should be reviewed on a regular basis, considering best practices and industry standards used for reserves of similar health care plans, and other factors and changes in the HSS operations that would affect it. The reserves should be monitored periodically during the year so that required actions to reduce Trust Fund surplus, or to adjust rates for shortfalls, can be taken as soon as possible.

8. Disclose the additional reserve to the HSS financial statements in order to clearly communicate the Board's intent and purpose in setting aside these funds.

CHAPTER 2
THE HEALTH SERVICE BOARD IS NOT SUFFICIENTLY FOCUSED ON BROAD POLICY ISSUES AND RISK MANAGEMENT

CHAPTER SUMMARY

The Health Service Board is not sufficiently focused on broad policy issues and risk management as a means of providing the review and oversight required of most fiduciary boards. This is largely due to the absence of a well-defined governance structure for the HSB, which would define the roles and responsibilities for HSB members, staff and consultants, and provide guidance in the oversight and strategic planning of HSS activities. The restrictive nature of certain Charter provisions further limits the Board in fulfilling its fiduciary obligations. Our research of best practices in board governance and our observations of other boards charged with comparable fiduciary responsibilities indicated that the most effective boards are given the authority and resources to operate at a policy development and review level, and are primarily responsible for the long-term direction and oversight of the organization. Members of such boards do not immerse themselves in detailed, operational decision-making. Without appropriate oversight, strategic planning and decision making from the Board, HSS cannot be adequately positioned to address future issues.

Roles and Responsibilities Assumed by the Board, Staff, and Consultants Need to be Appropriate and Well Defined

Because the HSB does not have a governance framework to define the roles and responsibilities among staff and Board, the Board has become deeply involved in the day-to-day operations and decision-making of HSS. A fiduciary board typically functions as a group and requires that a consensus of understanding be reached and a majority vote made on each item or topic addressed. Decision-making as a group on the daily operations of HSS is cumbersome, awkward and time-consuming, and does not represent the best use of time for HSB members**,** the HSS Director, staff, and consultants. The rate-setting process, one of the most important functions of the HSS operations, requires nearly six months to complete. In contrast, CalPERS requires approximately four months to design health care benefits and set the rates for the members of its health care plans. The HSS process is so long, in part because each of the topics introduced at these meetings is discussed in-depth by the commissioners, without the benefit of analysis or recommendations from HSS staff. These topics are then repeated at subsequent meetings, as HSB members attempt to obtain consensus and make decisions.

At the eleven HSB and committee meetings we attended between November 2004 and March 2005, we observed that health care topics brought forth for discussion were revisited, on average, three times at subsequent meetings. And yet, few if any final decisions or actions relating to the health care benefits were made prior to the final

meetings in the rate-setting process. For instance, at the January 11, 2005, Rates and Benefits Committee meeting, commissioners discussed a vision health care proposal at length for more than 1½ hours, even though this issue had been presented at two previous meetings. The vision care vendor's presentation did not include a summary analysis or recommendation for action from HSS staff. The discussion among the commissioners continued beyond the time allotted, taking time away from another agenda item, which was tabled to the next meeting. The Board spent a significant amount of time and effort discussing the details of this proposal—a task most boards would assign to staff—instead of maintaining a focus on broader policy-related concerns.

This already lengthy process is exacerbated by the submission of voluminous and complex documents from Towers Perrin, on whom commissioners rely heavily for information on health care benefits and rates. On numerous occasions during the rate-setting process, Towers Perrin presented its materials to the Board without sufficient time for review prior to the meeting. Staff from Towers Perrin have repeatedly stated that their role does not include providing recommendations or advice regarding rate-setting decisions. However, the lack of adequate time to review these materials also hinders the ability of HSS staff to provide informed recommendations to the Board. Without the benefit of due diligence and analysis prepared by staff or consultants in advance of Board and Committee meetings, HSB members must spend more time during meetings to understand the issues and reach their own conclusions about the information provided.

These inefficiencies in HSB procedures and decision making are due in part to a lack of clarity regarding the appropriate roles and lines of accountability among HSB members, the HSS Director and consultants. Seven different individuals have served as HSS Director since 1997; as a result, various leadership styles and competencies have defined the Director's role and its relationship to the Board, instead of a formal articulation of the appropriate responsibilities. This turnover in staff management also may have led commissioners to become overly engaged in the operational details of HSS in the absence of consistent organizational leadership. The role of Towers Perrin has also evolved over the past several years in response to changing needs within HSS. Currently, Towers Perrin's contract includes a broadly defined scope of actuarial, financial, and consulting services. The lack of specificity in its scope of work may contribute to the uncertainty we heard expressed by some regarding whether the actuarial consultant is accountable to the HSB or the HSS Director. The broad nature of Towers Perrin's contract also differed significantly from those we examined for consultants performing similar functions in four other California counties, which included more detailed deliverables for a well-defined set of services.

The Health Service Board Should Monitor and Assess Its Own Performance as a Fiduciary Body

The HSB does not have mechanisms in place to enable it to objectively monitor and formally report on its own performance. Such self-assessments have been determined to be a part of best practices for board governance, as they provide assurances to constituents and members of the public that a board is committed to following the rules

and guidelines of the organization. Further, regular reviews would enable the Board to monitor its own progress toward stated objectives, and to continuously improve its effectiveness as a fiduciary body. This measurement process would provide a standard framework for commissioners to raise concerns, identify areas of strength and weakness in their practices, and explore opportunities and strategies for improvement.

HSS and Its Board Need a Strategic Business Plan to Prioritize and Guide Activities

HSS is a multi-million dollar health care system, expending more than $400 million per year in claims and premiums. Between 2000 and 2004, total costs for all health benefits provided by HSS have increased by 87 percent. The employers' share of contributions toward health care premiums has increased by 85 percent, and that of employees by 39 percent. Despite the significant size of HSS operations and the persistently rising costs of providing health care coverage to members, the Board has not developed a strategic business plan to identify priority concerns and issues to be addressed on an annual or multi-year basis. For HSS, in addition to ongoing cost concerns, issues relevant to its new status as an independent department and the change in leadership are two developments that should be managed strategically over the next several years.

The absence of a formal plan to guide the Board's work is particularly challenging during the rate-setting process. Although Towers Perrin presents some industry trends and rate renewal estimates at the outset, the Rates and Benefits Committee does not establish a formal plan for systematically reviewing and voting on plan design changes or cost containment strategies. In some of the meetings we observed, commissioners had difficulty tracking their own progress, at times forgetting which issues had already been resolved, and those for which further information was required before making a decision.

Effective Governance Practices Were Identified Through Research and Review of Other Fiduciary Boards

Industry Research

Our audit testwork included research of best practices in the area of governance and board functions. In this research, we learned about a Toronto-based firm, Cortex Applied Research, Inc. (Cortex). Founded in 1991, Cortex's mission is to enhance the effectiveness of pension plan boards through the recommendation and implementation of governance best practices, sound business strategies, and fiduciary education. Although this firm's focus has been on the boards of pension plans, these concepts of governance and fiduciary responsibility apply to the HSB. In nearly 15 years of consulting, Cortex has determined that boards which incorporate clear decision-making structures, sound policy-setting processes, and relevant and timely reporting systems will better position board members to make prudent decisions and provide effective oversight. Such boards place a high importance on policy-driven processes, and recognize the need for a clear-cut description of roles and responsibilities for management, staff and board. In this way, all parties know their contributions to the success of the organization.

Our research of governance best practices also included those of corporate and nonprofit organizations. The results of this research also point to the advantages of policy-driven boards to have defined the roles of management, the board and staff. In this way, responsibilities are clearly allocated, and the oversight of the operations is not compromised. In seeking an appropriate local standard of comparison for governance practices at HSS, we examined the current governance procedures and observed board meetings of CalPERS and SFERS. We also interviewed staff from both organizations.

CalPERS

Governance structures and policies at CalPERS are consistent with the fundamental principles identified in our best practices research, especially related to role clarification among board and staff. In order to more fully meet the needs of constituents, and to maximize the effectiveness of board meetings, CalPERS staff meet with constituents prior to every board meeting to address questions or concerns they may have. In this way, the organization fosters a strong relationship with constituents, board members' time is used most efficiently, and there is a shared understanding of issues among CalPERS staff, constituents, and the board. CalPERS board and staff also engage in ongoing business planning. The staff prepare a Strategic Plan, with some direction from the board, which prioritizes key issues and decisions. This is a fluid document that is reviewed continuously. The board also adopts a Three-Year Business Plan with specific objectives that directly impact the business of CalPERS and are aligned toward the achievement of the goals identified in the Strategic Plan. Specific outcomes are established to measure the progress toward meeting the stated objectives. Board members also attend an annual retreat, which allows them to learn about and discuss in-depth topics such as leadership, strategic decisions, and federal and state policy trends.

SFERS

Our observations and review of the SFERS board also reinforced the advantages of a board focused on the governance of the organization and the designation of tasks and responsibilities among all parties. Through the diligent work of the board and the Director, SFERS has established a comprehensive governance structure and policies. These policies, or "Terms of Reference," define board and staff responsibilities in key areas such as investments, benefits administration, operations, human resources, communications, monitoring and reporting. They reinforce and elaborate on the SFERS Rules document required by the Charter, and are reviewed every two to three years to ensure their continued relevance. The SFERS Director gives credit to these policies and the structure they have created as significant factors contributing to the top-tier performance standing of SFERS among public pension plans of similar size. Among the SFERS Terms of Reference is a business planning policy, to provide a formal and deliberate approach to annual planning to best position SFERS to meet future challenges. During the initial planning stage each year, the Director and board review the status of the prior year's Business Plan, consider current business needs or opportunities, and develop a prioritized list of proposed initiatives.

The table below summarizes the elements of best practices for governances as identified in the board functions of HSS, CalPERS and SFERS.

Table 1: Governance Best Practices

	HSS	CalPERS	SFERS
Clear Definitions of Roles and Responsibilities for Board, Staff and Consultants	**N**	Y	Y
Formal Orientation and Training Curriculum for New Board Members	**N**	Y	Y
Trust Fund Reserve Policy Approved by Board and Reviewed Regularly	**N**	Y	Y
Regular Review of Actuarial Projections Versus Actual Experience	**N**	Y	Y
Periodic Evaluation of Consultant and/or Vendor Performance	**N**	Y	Y

The Board Needs to Better Address Significant Fiscal and Policy Concerns

Since the HSB has expended the majority of its efforts addressing the operational issues of HSS, certain long-term concerns and issues have been overlooked. For instance, HSS's annual budget was presented at the HSB meeting on March 10, 2005. This represents the proposed funding, programs and activities for HSS for the upcoming fiscal year. Most boards consider the review and analysis of the annual budget as one of their primary responsibilities. As such, certain efforts are generally taken to ensure that all board members have a full understanding of the underlying components of the budget. Since this budget represented the first annual budget of the newly independent HSS department, it would be reasonable to assume that HSB members would need to spend additional time and effort familiarizing themselves with the budgetary items and concerns for HSS. And yet, the discussion of the budget among the commissioners lasted no more than 15 minutes, with few substantive comments or observations. As noted in the examples provided above, this must be contrasted with the considerable time commissioners have expended on operational issues.

Other developments in the health care field include the ongoing implementation of Governmental Accounting Standards Board (GASB) Statements 43 and 45, which will require government-sponsored health plans to disclose the liabilities and obligations of medical benefits for their retired employees. The Medicare Modernization Act—effective January 2006—will allow eligible employers sponsoring medical benefits for retirees to be reimbursed for some claims. These are just some of the far-reaching issues that could have a significant impact on HSS and its membership. Nevertheless, our observations of the six Rates and Benefits Committees meetings and the five HSB meetings indicated that little time and effort has been devoted to such issues.

The City Charter Limits Effective Oversight of the Health Service System

The Charter is conflicted with regard to mandating the focus of the HSB, and to providing it the resources to fulfill these requirements. Section 12.201 of the Charter requires the HSB to act as a policy-driven board, stating, "The [HSS] Board and each committee of the [HSS] Board shall confine its activities to policy matters…." However, the qualifications for the appointed positions do not meet the requirements expected for HSB members making critical health decisions for more than 100,000 members and their dependents on an annual basis. Further, there has been no budgetary allocation for training commissioners in relevant areas, so that they can make competent decisions on behalf of HSS members. The Charter narrowly defines the types of administrative expenses that may be authorized by the HSB and paid from the Trust Fund. As a result, the HSB is hampered in its ability to make decisions from a sound knowledge base, and to ensure that the HSS is being administered effectively.

<u>HSB Appointments</u>

Charter section 12.200 notes that the Mayor is responsible for two appointments to the Board. One of these appointees must be a doctor of medicine, and the other must be an individual who regularly consults in the health care field. Our observations of the HSB and Committee meetings, and our analysis of issues and concerns that commissioners must address, suggest the need for the Board as a whole to possess skills, knowledge and experience in a broader range of professional fields such as health care, finance, insurance, employee benefits and financial management. However, neither of these appointed positions are required by the Charter to have the breadth of experience we have determined is warranted. We have further noted that the Mayor's appointed position of a doctor of medicine was vacant for nearly one year. We can surmise that the delay in appointing this member may relate to the difficulty in identifying an available individual whose qualifications fulfill this narrowly defined requirement.

The Charter also gives the Board of Supervisors authority to appoint a Supervisor to the HSB. This appointee, similar to the seat appointed by the Mayor, has no requirements relating to prior experience, knowledge or expertise. It is likely that the intention of the Charter was to provide for meaningful discourse between the HSB and the Supervisors, since the latter are responsible for the final approval of the annual rates and benefits for the City's health plans. Unfortunately, attendance by a member of the Supervisors has been low in recent years. The seat was vacated in August 2004 and remained unfilled during the last rate-setting process. When last filled, the previous appointee attended less than half of the meetings (between January 2003 and June 2004). This may be due to other responsibilities and commitments of the Board of Supervisors, which preclude regular attendance at the HSB and committee meetings. However, these prolonged absences have created a void in the communications between the HSB and the Board of Supervisors, and lessened the effectiveness of the HSB's decision-making function.

<u>Administrative Expenses</u>

Although the Charter requires that contributions to the HSS Trust Fund be sufficient to "… efficiently administer the HSS," it also states that only those expenses relating to

obtaining and distributing information about plan benefits to HSS members may be approved by the HSB and paid from the Trust Fund. Those expenses relating to information about plan benefits are primarily costs associated with annual open enrollment. This Charter directive differs from the authority given to other boards to manage and administer Trust Funds. For example, the administrative costs of SFERS, which have been adopted and approved by the SFERS board and the Board of Supervisors, are paid from the SFERS Trust Fund. Specifically, the SFERS board may approve expenditures to educate and train commissioners so that they can make informed and knowledgeable decisions for the members of the City's retirement system. In total, these costs for board education (and related travel) comprise less than one percent of the SFERS annual administrative budget.

We learned that none of the HSB members had attended any relevant trainings in the past several years. In contrast, our observations of other boards (SFERS and CalPERS) indicated that the training and education of their board members was both commonplace and expected. For instance, newly appointed or elected members to the SFERS and CalPERS boards are expected to complete a formal orientation in order to introduce them to staff and other board members, explain the Codes of Conduct, and clarify other rules and procedures. Further, training is planned for and provided on an annual basis for these board members, based on current developments or changes in the industry. Without a consistent funding source for proper education and training, there is a risk that HSB members are not sufficiently informed to make the critical decisions required of them.

Many HSS functions depend on membership records and data. The current membership accounting system records vital information used by HSS on a daily basis to record members' enrollment, claims and other pertinent information. Currently, this system is outdated and unsupported by the manufacturer. And yet, this membership system represents the bulk of the administrative functions of HSS. As noted above, administrative costs of other trust funds, such as SFERS, are governed by the board, and paid from the trust fund. Without adequate resources and funding to maintain this system, HSS cannot be assured that members are enrolled accurately and that other personal and eligibility information is correct. Further, since the availability of funding guides the long-term planning of necessary projects for this system, reliance on the precarious annual budgetary process will not provide assurance that upgrades and regular maintenance support will be performed. Additionally, an upgrade to the membership accounting system would promote efficiencies and cost savings in the enrollment process, and enable members to have greater flexibility and access to their benefit information.

RECOMMENDATIONS

9. Conduct a thorough review of the roles and responsibilities currently distributed among Board officers, members and committees, senior HSS staff, and contractors (i.e., the actuary and health care vendors), considering those duties defined by the Charter, and additional duties necessary to provide effective management and oversight of HSS. Prepare formal, written documentation of

roles and responsibilities, distribute them to all relevant parties, and review them on a regular basis to ensure their continued relevance.

10. Develop a self-evaluation process, whereby the HSB monitors and reports on its own performance. The Board may consider enlisting the assistance of consultants specializing in board governance, which has proved beneficial for other fiduciary boards, such as the SFERS board.

11. Develop and adopt a strategic plan, focusing on issues and concerns affecting HSS over the next several years. Such a plan should include system-wide objectives and strategies for meeting these objectives, allowing for time frames and expected completion dates. Periodic reporting and evaluation of the Board's progress towards its goals, as well as regular updating should be part of the strategic planning process.

12. Work with City leadership to revise Charter section 12.200 to expand the options for the Mayoral appointee, who currently must be a doctor of medicine, to include experience and expertise in clinical medicine (e.g., nurse, dietician, pharmacist).

13. Work with City leadership to revise Charter section 12.200 to expand the qualifications for the Mayoral appointee who must have experience in the health care field to include health care benefits, insurance, finance, accounting, actuarial or business.

14. Work with City leadership to revise Charter section 12.200 so that the member appointed by the President of the Board of Supervisors need not be a current member of the Board of Supervisors. The qualifications for this appointee should include knowledge and/or expertise in health care benefits, insurance, finance, accounting, actuarial or business.

15. Work with City leadership to revise Charter section A8.423 to allow for a broader range of eligible administrative expenditures from the Trust Fund at the discretion of the Board, including upgrades to and ongoing maintenance of HSS information technology systems and costs related to the education and training of HSB members. The amendment should allow these costs to be built into a rate structure that would appropriately spread costs across City departments and members.

CHAPTER 3
A MODEL FOR A MORE EFFECTIVE HEALTH SERVICE BOARD

CHAPTER SUMMARY

Through surveys of other state and local municipalities, observations of comparable fiduciary boards, and interviews with governance experts, we developed a comprehensive picture of the model elements of effective board governance. These fundamentals help to ensure that boards fulfill their fiduciary responsibilities, and maximize their potential to achieve success in the organizations they oversee. The core principles of effective governance are as follows:

Role Clarity

Role clarity is the foundation of the most effective boards. On the most basic level, this confirms that a board's role is to focus on broad policy issues, business planning and risk management, while staff are responsible for operational and implementation issues. Defining specific tasks to be performed—beyond this general separation of duties—also establishes clear expectations and lines of accountability so that all parties understand their respective contributions to the organization. Specific roles and responsibilities across board members and officers, staff and key consultants should be consistent with the mission and goals of the organization.

Policies and Procedures

Once roles and responsibilities are clearly defined and assigned, model boards develop a comprehensive set of governance policies to guide their activities. Such policies are designed to streamline the board's operations by explicitly defining the terms and conditions under which various board functions are accomplished. Governance policies may address a range of issues, depending on the organization's work and the scope of board responsibilities. Such policies include but are not limited to the following areas: annual planning; board officer and committee functions; codes of conduct; education and training; internal and external communications; contractor selection and monitoring; performance reviews of key personnel; and regulation of trust fund reserves.

Strategic Planning

Boards function most effectively when there is a shared understanding among board members, staff and constituents regarding the purpose, goals and priorities of the organization. Establishing mutual agreement on goals and priorities is most effectively accomplished through a formal, annual strategic planning process. Through a deliberate approach to planning—which requires leadership or significant participation from staff—model boards identify current needs and opportunities and define successful outcomes for their organizations. Priorities are established, a formal list of objectives to be achieved in the coming year is developed, and board members measure their progress toward achieving those objectives on a regular basis. In doing so, boards are well positioned to address future challenges that may arise.

Education and Training

To maximize their performance, strong boards ensure that all members have adequate opportunities and assistance to acquire the knowledge they need to effectively carry out their duties. This knowledge-building process generally begins with a thorough orientation for new board members that both clarifies expectations and ensures their understanding of the organization's core business. In most cases, either staff or a formal board policy will identify educational resources available to board members. These may range from the more traditional annual industry conferences, to quarterly workshops or seminars coordinated by staff and tailored to specific board needs or interests. By creating a standard training program, boards ensure that there is a commonly understood knowledge base among all members.

Reporting and Communications

Effective boards recognize what types of information they need to be most effective in their role, and how often and in what format they require this information. The materials shared among board members and staff are regularly reviewed for content, level of detail, frequency, and appropriateness. Once determined, these materials are distributed to board members with sufficient time to allow them to review complex issues or analyses, and to prepare for meetings. Exemplary boards also recognize the importance of keeping their constituents and other stakeholders well informed. This includes providing easy access to general information about board policies and procedures. In some cases, boards publish an annual report that summarizes their key accomplishments and future plans. Through strategic communications with interested parties, accurate information is transmitted in a consistent and timely fashion to the board, staff and constituents. This helps to mitigate misunderstandings, confusion or anxiety regarding complex or politically charged issues, which enhances the efficiency of board proceedings.

Contractor Selection and Performance Review

In order to establish clear expectations and lines of accountability with their paid consultants, most boards develop formal guidelines by which contractors are selected, monitored and terminated. Such policies seek to ensure that the process of selecting and terminating providers is efficient, diligent and fair; that appropriate services are obtained at a competitive cost; and that local purchasing and contract requirements are met. Our comparative research indicated that performance measures and deliverables are also clearly stated and enforced in contracts with consultants and health care vendors. Most counties we spoke with competitively bid out their consultant and vendor contracts every three to five years.

Staff: Brenda Roberts, Manager
Michael Wylie
Sally Allen

Appendix A
Health Benefits Survey Findings by County

SUMMARY OF FINDINGS:

In collaboration with HSS, the audit team developed a survey to gather information from other municipalities regarding health benefits administration, governance, funding and coverage; and regarding healthcare cost containment strategies and best practices resources. A 22-question survey was emailed to 12 California counties and one city on 12/10/04. Information obtained from the nine responding counties is presented below, and compared with the City and County of San Francisco.

Administration, Plan Design and Rate Setting

San Francisco's Health Service System is unique in its status as an independent city department, and its oversight by a Health Service Board. In nearly all counties surveyed, the Human Resources Department is responsible for the day-to-day administration of benefits, and for decisions regarding plan design or rates. With the exception of Santa Clara, these counties contract with benefits consultants, brokers or actuarial experts to conduct annual negotiations with healthcare vendors. Orange and San Joaquin Counties follow CCSF's use of an actuarial consultant in this role. Unlike San Francisco, health benefits and employer/employee cost-sharing agreements are largely negotiated through the collective bargaining process. This differs from CCSF, whose baseline employer contribution to health care premiums is determined by the annual 10-County Survey required by the Charter.

Benefits Funding

Healthcare costs for active employees are funded out of the General Fund in six of the nine counties surveyed. Seven of the nine counties noted that they maintain reserves for at least one self-insured health plan (not applicable in Sacramento and Ventura). Fund reserve amounts for these self-insured plans varied. All counties maintain a minimum of IBNR reserves, which ranged from 1.5 to 2.5 months' worth of claims. San Francisco has a mix of contribution rates. The baseline health rate is determined by surveying other counties (the 10-County Survey). The dependent contribution rate and other benefits are set in collective bargaining. Under Proposition E, San Francisco pays 50% of the premium for retirees and their first dependent. San Francisco also maintains reserves in the Health Service Trust Fund for its one self-insured plan (known as "City Plan" or "Plan 1"); however, actual reserves in this trust have exceeded the total target reserve amount over the past several years.

Benefits Offerings

Compared to its peers, San Francisco offers a richer set of health benefits to employees and retirees. Most notably, San Francisco employees vest at five years of service for 100% of retiree health benefit coverage, whereas vesting periods in other counties ranged from five to ten years of service. The subsidy amounts varied by years of service and/or bargaining unit; in some cases it was based on the lowest-cost HMO plan. San Francisco also provides up to five years of subsidized healthcare coverage to permanent civil service employees who are unable to obtain coverage elsewhere -- a benefit not offered in any other county.

Cost Management and Best Practices

Seven of the nine counties noted that they have adopted plan design modifications (e.g., adjusting co-payments, vesting periods, etc.) as a cost containment strategy for their benefit programs. Disease management or wellness programs and higher cost sharing (i.e., asking employees to contribute more toward their premiums) were the other most commonly noted strategies. In contrast, San Francisco's Health Service Board did not approve any changes to health plans for FY2005-06 that would impact costs. In past years, however, the HSB has adopted some plan design modifications (e.g., tiered pharmacy co-pays).

COUNTY:	San Francisco	Alameda	Contra Costa	Orange	Riverside	Sacramento	San Diego	San Joaquin	Santa Clara	Ventura
GENERAL INFORMATION:										
County Population as of 1/1/05	799,263	1,507,500	1,020,898	3,056,865	1,877,000	1,369,855	3,051,280	653,333	1,759,585	813,052
Total Enrollment	56,069 (+ dependents)	12,157	11,717	39,822	14,864 (+ dependents)	17,478 (+ dependents)	14,000	11,000	19,616	12,923
Total Enrollment by Employment Status	ACTIVE: 38,267 RETIRED: 20,862 DEPENDENT: 49,207	ACTIVE: 2,670 RETIRED: 3,737 DEPENDENT: 5,750	ACTIVE: 7,974 RETIRED: 3,743 DEPENDENT: Information not available	ACTIVE: 17,324 RETIRED: 4,659 DEPENDENT: 17,839	ACTIVE: 13,309 RETIRED: 1,555 DEPENDENT: Information not available	ACTIVE: 13,006 RETIRED: 4,472 DEPENDENT: Information not available	ACTIVE: 14,000 RETIRED: 11,000 DEPENDENT: Information not available	ACTIVE: 6,500 RETIRED: 1,500 DEPENDENT: 3,000	ACTIVE: 13,416 RETIRED: 6,200 DEPENDENT: Information not available	ACTIVE: 5,367 RETIRED: N/A DEPENDENT: 7,556
Enrollment by Plan Type	HMO: 85% / PPO: 15%	HMO: 90% / PPO: 10%	Information not available	HMO: 70% / PPO: 30%	HMO: 98% / PPO: 2%	HMO: 81% / PPO: 19%	HMO: 51% / PPO: 49%	HMO: 30% / PPO: 70%	Information not available	HMO: 99% / PPO: 1%
Plans Offered	HMOs (Blue Shield, HealthNet, Kaiser); PPO (City Health Plan)	HMOs (HealthNet, Kaiser); PPO (HealthNet)	HMOs (HealthNet, Kaiser); PPO (HealthNet, County Health Plan)	HMOs (Kaiser, CIGNA Private Practice); PPOs (Premier Wellwise, PremierSharewell)	EPO (Exclusive Care); HMOs (HealthNet, Kaiser, PacifiCare); PPO (PacifiCare)	HMOs (Blue Cross, Blue Shield, HealthNet, Kaiser); PPO (Blue Shield Select); POS (HealthNet); Catastrophic Plan (Blue Cross)	Actives (Kaiser, PacifiCare); Retirees (HealthNet HMO, Kaiser, PacifiCare HMO, PacifiCare PPO)	Kaiser, County Managed Care Plan 2, County Managed Choice Core and Point of Service	HMOs (Kaiser, Valley Health Plan); PPO (HealthNet); POS (HealthNet)	PacifiCare HMO, County Health Plan
ADMINISTRATION, PLAN DESIGN, RATE SETTING:										
Entity responsible for day-to-day administration of employee health benefits	Health Service System (independent department)	Department of Human Resources	Department of Human Resources	Department of Human Resources. County contracts out for member services, open enrollment and claims processing.	Department of Human Resources	Employee Benefits Office within Department of Employment Services and Risk Management	Department of Human Resources	Department of Human Resources	Department of Human Resources	Department of Human Resources
Entity responsible for plan design or rate-setting decisions	Health Service Board	Benefits Analyst	Department of Human Resources	Department of Human Resources and Labor/Management Organization	Department of Human Resources	Employee Benefits Office within Department of Employment Services and Risk Management	Department of Human Resources	Department of Human Resources	Labor/Management Organization	Department of Human Resources
Specific expertise/training requirements for above decision makers	For appointed Board members only (1 must be doctor of medicine; 1 must have insurance industry experience)	Yes: At least 5 years of benefits background	Yes	No	Yes: Employee benefits experience	No	Yes: Combination of education and experience	No	No	No
Entity with authority for final plan design or rate-setting decisions	Board of Supervisors	Board of Supervisors	Board of Supervisors	Board of Supervisors	Board of Supervisors	Board of Supervisors	Board of Supervisors	Board of Supervisors	Board of Supervisors	Board of Supervisors
Entity responsible for annual negotiation of healthcare premiums	Actuarial consultant	Benefits Analyst, working with broker	Benefits consultants	Department of Human Resources, working with actuarial consultant	Broker	Broker	Broker	Actuarial consultant	Department of Human Resources	Broker

Appendix A
Health Benefits Survey Findings by County

COUNTY:	San Francisco	Alameda	Contra Costa	Orange	Riverside	Sacramento	San Diego	San Joaquin	Santa Clara	Ventura
Cost-sharing arrangements	County's share of active employee premiums based on average of ten most populous California counties (10-County Survey)	County's share of premiums based on lowest-cost HMO plan	County contributions vary by MOU	County pays 95% of premium for full time, employee-only coverage	Cost sharing is negotiated	For most employees, county contributes 80% of Kaiser family rate	County gives baseline dollar amount to each bargaining unit to apply toward salary and/or benefits	County pays full cost of single rate for all plans, 80% for dependents	For full-time employees, County pays full cost of the single rate for all health plans and full cost of the family rates for Kaiser and Valley Health regardless of family structure	County generally covers 2/3 of premium for outside HMO, 90% of premium for County plan
BENEFITS FUNDING:										
Method of health care funding for active employees	Trust funded by General Fund and employee contributions	Trust, with employee contributions	General Fund	General Fund, plus state and federal sources	Information not available	General Fund; each department pays for its own medical benefits	Trust; flex credits deducted from paychecks contributed to fund; amounts vary by bargaining unit	General Fund	General Fund	General Fund; departments are billed
Method of health care funding for retired employees	Trust funded by General Fund and employee/retiree contributions. Employer pays 50% of out-of-pocket costs for retiree and first dependent.	Trust. Retirees receive a stipend based on years of service; dependents of retirees pay full premium	General Fund	Retiree Medical Insurance Program assists retirees with the cost of retiree health insurance premiums and/or Medicare premiums. Employees contribute 1% of gross pay each pay period to the program.	Information not available	General Fund. Health care not a vested benefit for retirees.	Trust funded from a portion of excess earnings from the general Retirement Association Fund. Health care not a guaranteed benefit.	Retired employees hired after 8/27/01 pay 100% of premiums. Retired employees hired before this date may have the option to use a portion of sick leave accrual balance as a cash pay-out and/or to take the balance to pay for monthly health and dental premiums.	Trust. Annual employer contributions based on actuarial valuation. County has a goal to pre-fund 100% of projected liabilities.	Retirees pay 100% of premiums.
Amount of reserves held for self-insured plans	IBNR plus additional reserve. Total target reserves equivalent to 4 months medical, 2.5 months dental, 1 month pharmacy.	1.5 months (IBNR only)	1.5 months (dental only, includes IBNR)	3 months	Information not available	Not applicable	2 months (dental and vision only)	IBNR plus "catastrophic reserve" at 2.5 months of expected claims (1 medical, 1 dental)	IBNR, plus an additional reserve calculated and recommended by actuary	$1.5 million "tangible net asset" requirement for County health plan
BENEFITS OFFERINGS:										
Retiree healthcare vesting requirements	Vested at 50 years of age and 5 years of service	Vested at 10 years of service	Information not available	Vested at 50 years of age and 10 years of service	Vested at 50 years of age and 5 years of service	Health care not a vested benefit for retirees	Vested at 10 years of service	Vested at 55 years of age and 5 years of service	Vested at 50 years of age and 8 years of service (5 yrs of service if hired before 8/12/96)	Vested at 5 years of service (management only)
Provide taxable cash payments for employees who waive coverage	No	Yes	No	No	Yes	Waiver is not allowed	No	Yes	Yes	Yes
Provide subsidized healthcare to permanent civil service employees who are laid off	Yes up to five years, if individual is eligible and unable to obtain coverage elsewhere	No	No	No	No	No	No	No	No	No
Provide subsidized healthcare to elected/appointed members of City/County Boards	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	No
Provide subsidized healthcare to Surviving Spouse or Dependents	Surviving spouse or domestic partner of retired employee; subsidy is NOT dependent on pension eligibility of deceased	Information not available	Information not available	Surviving spouse or domestic partner of retired employee; subsidy is dependent on pension eligibility of deceased	Surviving spouse or domestic partner of retired employee; subsidy is dependent on pension eligibility of deceased	Surviving spouse or domestic partner and dependents of retired employee; subsidy is dependent on pension eligibility of deceased	Surviving spouse or domestic partner of retired employee; subsidy is dependent on pension eligibility of deceased	Information not available	Surviving spouse or domestic partner of retired employee; county makes no contribution toward coverage	Information not available
COST MANAGEMENT AND BEST PRACTICES:										
Cost containment strategies	None for 2005-06 plan year	Plan design modifications	Disease management/wellness programs; higher cost sharing; plan design modifications	High deductible plans; higher cost sharing; plan design modifications	Consumer-driven plans; higher cost sharing; plan design modifications	Disease management/wellness programs; plan design modifications	Disease management/wellness programs; higher cost sharing; plan design modifications	Plan design modifications	Information not available	Disease management/wellness programs
Best practices resources*	Consultants/Actuaries	Industry conferences or seminars, Consultants/Actuaries	Consultants/Actuaries	Industry conferences or seminars, Consultants/Actuaries	Industry conferences or seminars, Consultants/Actuaries	Industry conferences or seminars, Consultants/Actuaries	Industry conferences or seminars, Consultants/Actuaries	Consultants/Actuaries	Industry conferences or seminars, Consultants/Actuaries	Industry conferences or seminars, Consultants/Actuaries
WEBSITES FOR MORE INFORMATION:										
	http://www.sfgov.org /site/dhr_page.asp?id=467	http://www.co.alameda.ca.us/hrs/index.htm	http://www.co.contra-costa.ca.us/depart/hr/default.htm	http://www.oc.ca.gov /hr/employeebenefits/health.asp	http://www.workforce exchange.net:8080/wfe/benefits/index.htm	http://hra.co.sacramento.ca.us /employ/ben/content.html	http://www.sdcounty.ca.gov /hr/	http://www.co.san-joaquin.ca.us/hr/	http://www.sccgov.org /channel/0,4770,chid%253D343298%2526sid%253D11701,00.html	http://www.ventura.org /hr/index.htm

* Industry resources identified included: International Foundation of Employee Benefit Plans (IFEBP); Society for Human Resource Management (SHRM); State and Local Government Benefits Association (SALGBA)

Appendix B
Terms of Reference

The following are general descriptions of the key governance policies—or *terms of reference*—discussed in the report. This list includes policies that would be relevant to the Health Service Board in defining its duties and responsibilities in areas such as governance, operations, business planning, communications, education, and monitoring and reporting.

PRESIDENT /VICE PRESIDENT TERMS OF REFERENCE

The purpose of these policies is to explain the duties and functions of the Board President and Vice President. In addition to defining length of service and election/nomination procedures, these policies specify the responsibilities of these officeholders. For the President, such duties may include: appointment of Board members to committees; presiding at all Board meetings; acting as the spokesperson for the Board; and ensuring that the Board discharges its duties and responsibilities as set forth in legal ordinances and other policies. For the Vice President, such duties primarily include assuming the duties of the President when he/she is absent or when designated to do so.

COMMITTEE TERMS OF REFERENCE

Separate terms of reference should be developed for each committee of the Board. These should identify the committee's composition, define its operational rules (e.g., meeting times, what constitutes a quorum, etc.), and specify all duties and responsibilities of committee members. If appropriate, these policies should also provide guidelines for annual processes (e.g., annual planning, budget preparation, rate-setting).

EXECUTIVE DIRECTOR TERMS OF REFERENCE

The purpose of this document is to define the roles and responsibilities of the Executive Director in major areas of the organization's work. While much of this may be included in the job description developed when hiring for the position, further specification may help to delineate roles between the Board and Director, and to explain how both parties are expected to work together. This policy should make clear that the Director is responsible for all operations and the day-to-day management of the organization. In addition, the Director may be expected to identify and make recommendations regarding issues requiring Board attention or action; coordinate or provide Board orientation and ongoing training opportunities; and in general assist the Board in carrying out its oversight responsibilities.

BOARD DEVELOPMENT PROCESS POLICY

The purpose of this policy is to define a process for the Board to conduct a self-assessment in order to develop and improve its effectiveness as a fiduciary body. The review of the Board's performance should be performed by all Board members, and be limited to the internal operations and decision-making practices of the Board. This policy should define a process by which Board members can provide input (e.g., written comments), and include guidelines for the documentation and reporting of their input.

BOARD EDUCATION AND TRAVEL POLICY

This policy seeks to ensure that Board members have adequate opportunity and assistance to acquire the knowledge they need to effectively carry out their fiduciary duties. It

should specify the minimum educational goals and expectations for Board members (including a list of appropriate and/or necessary topics in which Board members should become familiar), and provide guidelines regarding acceptable travel for relevant educational purposes. In addition, this policy might outline a formal orientation program for new Board members, as well as identify ongoing training opportunities such as conferences, seminars, or in-house workshops.

BUSINESS PLANNING POLICY

The purpose of this policy is to define a strategic approach to business planning, in order that an organization may be in the best position to meet future challenges. Through a formal business plan, the Board can prepare for future needs, achieve consensus among the Board and Executive Director, and communicate priorities throughout the organization. A business plan is intended to address new or special initiatives having a significant impact on the organization, and should include current business needs, risks, opportunities and proposed initiatives based on data and analyses. In the case of HSS, such a plan might include analyses of the following: membership demographics; relevant pending Charter amendments or changes in other regulatory laws; trends in health care costs and strategies to address them; and potential projects to enhance the internal operations or customer service functions of HSS. Since business planning is an ongoing process, the plan should be reviewed by the Board and staff and updated at least annually.

CODE OF CONDUCT POLICY

The purpose of this policy is to guide how the Board and individual Board members are expected to conduct themselves when discharging their duties. It should include guidelines regarding Board members' preparation for, attendance at, and behavior during Board and committee meetings, and regarding their general professionalism in their relations with Board members, HSS staff and other constituents. In addition, this policy may specify expectations regarding compliance with rules or policies; communications with external parties; and procedures for reporting any breaches of the Code (e.g., censure).

COMMUNICATIONS PLANNING POLICY

The purpose of this policy is to define a strategic approach to communications planning, to ensure that all parties (both internal and external) have access to timely and accurate information. It should identify and implement standardized communication activities to meet the goals and objectives of the organization and should address both short and long-term planning needs of the organization. For example, the Board should identify what types of information it needs to be most effective, and how often and in what format it requires this information. Changes in systems, which would affect the format, frequency and type of communications should be anticipated and included in the business planning of the organization. External communication activities should be defined and standardized, and may range from publications (e.g., annual report, enrollment guide, etc.) to website offerings or meetings with constituent groups. The plan should be reviewed by the Board and staff and updated at least annually.

Appendix B
Terms of Reference

CONTRACTOR SELECTION POLICY

The purpose of this policy is to establish general guidelines by which contractors are selected, retained and terminated. This policy seeks to ensure that the appointment and termination of contractors is made in the best interests of the organization; that the process of selecting and terminating contractors is efficient and fair; that appropriate services are obtained at a competitive cost; and that purchasing and contract requirements are met. This policy should identify the responsible parties for appointing and recommending contractors, and define the process by which the Board and staff will work together to solicit, evaluate and select candidates for contracting relationships. In addition, it should specify guidelines and criteria for periodic monitoring and reviews of contractor performance, and for contract renewal procedures.

MONITORING AND REPORTING POLICY

The purpose of this policy is to clarify expectations concerning the regular reports the Board receives from various sources, and to identify those documents or entities that should be routinely monitored. This policy should specify the report name, purpose, source, presenter, and frequency of each report presented before the Board. For example, these may include the Executive Director's report, the President's report, legal updates, financial reports, or actuarial analyses. The policy should also provide guidelines regarding how often and in what form the Board should monitor such items as the annual budget, the business and communications plans, and governance policies. If appropriate, this policy should also direct the Board in its monitoring of the performance of the Executive Director as well as key consultants working with the organization.

APPENDIX X

RESPONSE TO THE AUDIT
HEALTH SERVICE SYSTEM

HEALTH SERVICE SYSTEM
City and County of San Francisco
1145 Market Street, Suite 200
San Francisco, California 94103

Bart Duncan
Director

June 24, 2005

Mr. Ed Harrington
Controller
City Hall, Room 316
1 Dr. Carlton B. Goodlett Place
San Francisco, CA 94102

Thank you for your audit report regarding the Health Service System (HSS).

This report could not have come at a more opportune time. As HSS now becomes an independent department on July 1, 2005, we are firmly committed to taking a hard look at all aspects of the system, learning from the past, but focusing in a positive and constructive fashion on the future. This report will be a tremendous tool for us as we embark on that effort.

We recognize that the report does not purport to be a comprehensive history of HSS, and, consistent with the constructive approach mentioned above, we do not wish to quibble over any of the contents of the report. Our focus instead is on the many excellent recommendations contained in the report, which will help us to put together a road map for our future progress and success. These recommendations clearly show a desire to help the Board and the new department better carry out our mission. More detailed responses to each specific recommendation are attached.

Like you, we believe that we can make tremendous improvements not only in the way the Board functions but also in our delivery of services to our members. We will not be able to do it alone, however, and we appreciate your generous offer to work with us in implementing your recommendations and in carrying out other initiatives that may be identified in the future.

On behalf of the Board and HSS staff, we would like to extend special thanks to Peg Stevenson, Brenda Roberts, Sally Allen and Mike Wylie for the research, analysis and hard work that made this report possible.

We look forward to working with you to improve HSS and to make the new department a resounding success.

Very truly yours,

Bart Duncan

Attachment

ADMINISTRATION 415-554-1727 · ADMINISTRATION FAX 415-554-1752

RESPONSE TO THE AUDIT
HEALTH SERVICE SYSTEM

Recommendation	Agree/Disagree	Comments
#1	AGREE	We agree that a comprehensive review of actuaries and medical plan vendors is an important part of the rate-setting process. This process should occur at the end of each plan year and prior to the rate-setting process for the next fiscal year. This process will include a comprehensive report by the actuaries regarding their projections and an explanation of variances. Also included should be a comprehensive report from each healthcare plan discussing performance guarantees and overall vendor performance for the prior plan year. A formal process will also set the tone for the rate-setting process.
#2	AGREE	The annual rate-setting process is itself a review of the City Health Plan rates. The process can be enhanced to include a review of actual projections with actuarial results for the prior year and explanations of any differences that may have resulted. This process will also provide information that will be useful prior to the beginning of the rate-setting process.
#3	AGREE	We agree that this process can be improved and formalized. An RFP process similar to the one used in 2000 will be an important part of such a process.
#4	AGREE	We agree that as part of the rate-setting process, the evaluation and consideration of potential healthcare cost reduction measures is important. While certain information has been a standard part of the process it may be possible to use a more focused approach.
#5	AGREE	We agree that a change to Charter Section A8.423 is necessary. A change to this section will eliminate significant overpayments by the City and the need for the Health Service Board to engage in discussions or planning regarding the best use of these "gap dollars" each year. While we agree that the use of an average formula will result in an amount that more accurately represents the cost of the counties surveyed, the data required to compute a true average is not available from all counties prior to the deadlines required by the Charter.
#6	AGREE	We agree that a formal policy will assist in the education and understanding of both board members and HSS members.

Recommendation	Agree/Disagree	Comments
#7	AGREE	We agree that a formal policy documenting required reserves and the information, data and actuarial formulas used to calculate such reserves, would be beneficial. A formal policy will provide a guide for Health Service Board members as well as members of HSS and will help to ensure an understanding of the concept of IBNR reserves, why they are needed and how they are calculated. A periodic review of the reserves will ensure a more accurate picture of the HSS Trust for purposes of setting annual rates and can be used as a measure of actuarial performance. It should be noted, however, that adjustments to rates or approved HSS Trust subsidies can only be considered and implemented on an annual basis in connection with the annual enrollment process.
#8	AGREE	We agree that disclosing the additional reserve on the HSS financial statements will more accurately reflect the information used by the Health Service Board when deciding on the appropriate rates, subsidies, etc to be applied in any given year.
#9	AGREE	In January 2005, the City Attorney provided to all Health Service Board members a copy of Opinion No. 2003-01. This document outlines the roles of a commission, individual commissioners and the department head. This document can be used as a template to create a policy specific to the Health Service Board and HSS Department Head that can then be reviewed and updated as necessary.
#10	AGREE	This is an excellent idea, and we are encouraged by the success that the Retirement Board had in taking this approach. We are hoping for funding in the 2005-2006 fiscal year that will enable us to get started as soon as possible.
#11	AGREE	This recommendation includes two different processes. A strategic plan will be developed at the department level identifying both short- and long-term goals and objectives. This plan will be fluid and subject to constant change as the department develops. The Health Service Board may also, as part of its own governance policies, decide to implement a self-reporting and evaluation process to track its progress and success.

Recommendation	Agree/Disagree	Comments
#12	AGREE	The current Mayoral appointees more than meet the requirements recommended by the audit staff. We agree that it is important however, to expand the requirements in a Charter amendment to section 12.200 to ensure the continued appointment of qualified individuals to the Health Service Board.
#13	AGREE	The current Mayoral appointee more than meets the requirements recommended by the audit staff. We agree that it is important however, to expand the requirements in a Charter amendment to section 12.200 to ensure the continued appointment of qualified individuals to the Health Service Board.
#14	AGREE	It is important that the Board of Supervisors is represented on the Health Service Board. The decisions and actions taken by the Health Service Board affect all City employees and retirees and deserve a high level of attention and input from the City's legislative body. We agree that it is not necessary that an actual member of the Board of Supervisors be appointed. A qualified representative of the Board of Supervisors, however, would facilitate regular participation in the activities of the Health Service Board and effective and informed decisions.
#15	AGREE	A change to Charter Section A8.423 would allow the Health Service Board the ability to provide for necessary funds required to maintain effective systems needed to deliver services to its customers and to ensure access to training and educational opportunities in an ever-changing healthcare environment.