Empower Results®

Empower Results®

Feedback Guide Contents

NAME _____

EMAIL _____

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Vendor Presentations

Specialty Topics

Introduction

Feedback	
Which group(s) do you represent?	☐ Active Employees ☐ Early Retirees ☐ Medicare Retirees ☐ CCSF ☐ SFUSD ☐ CC ☐ Other _____
How do you feel the SFHSS benefits meet the needs of its members?	
Does your answer above differ for active employees versus retirees?	
What are you hoping to learn today?	
What are you concerns going into the conversation today?	

Notes

Today's Session	
How do you feel going into of this conversation?	

Today's Realities

KEY TAKE-A-WAYS

- Workforce diversity brings different needs, preferences and value drivers
- Unhealthy workforce adds cost to the system and has negative productivity impact
- Cost does not equate to quality and significant inefficiencies are in the system today
- Employees, retirees and families are left in a quandary when care is needed
- Technology is beginning new innovation into the entire health supply chain
- Social determinant have a significant impact on health

Feedback	
What surprised you about what you heard today?	
What concerns you?	
What excites you?	
How can SFHSS be involved in addressing some of the issues identified?	
Does your answer above differ for active employees versus retirees?	
How can you or your constituents be involved in addressing some of the issues?	
What would you like to hear more about from this topic?	

Scoring Today's Session	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
How much knowledge did you gain from this session?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
How much value did you gain from this session?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
How realistic is it to apply some of these ideas to the SFHSS program?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1

Notes (continued)

Culture of Wellbeing

Clinical and Care Management

Notes

Introduction

Today's Realities

Culture of Wellbeing

KEY TAKE-A-WAYS

- Culture and Workplace Environment matter
- Holistic approach to wellbeing positively impacts engagement
- Emotional and financial health need to be addressed
- Personal technology and apps are accelerating

Feedback	
What surprised you about what you heard today?	
What concerns you?	
What excites you?	
How can SFHSS continue to create a positive culture of health?	
Does your answer above differ for active employees versus retirees?	
How can you or your constituents be involved in continuing a positive culture of health?	
What would you like to hear more about from this topic?	

Scoring Today's Session	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
How much knowledge did you gain from this session?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
How much value did you gain from this session?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
How realistic is it to apply some of these ideas to the SFHSS program?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1

Clinical and Care Management

KEY TAKE-A-WAYS

- Team based, patient centered, coordinated care is high value
- Value based systems encourage quality outcomes and improved cost
- Population health management and predictive analytics enhance effective care
- Provider optimization guides members to high value providers with better quality and improved cost

Feedback	
What surprised you about what you heard today?	
What concerns you?	
What excites you?	
What ideas do you think would fit best into SFHSS' goals?	
What areas do you think are beyond SFHSS' reach?	
What would you like to hear more about from this topic?	

Scoring Today's Session	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
How much knowledge did you gain from this session?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
How much value did you gain from this session?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
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Glossary and Acronyms (continued)

Preferred Provider Organization (PPO) — A form of managed care in which employees choose to use network or non-network providers when care is needed; there is no primary care physician.

Premium — The fee paid to a health insurance carrier by an enrolled company or individual, normally on a monthly basis, for the delivery and financing of healthcare services to the employees or the individual, and their dependents enrolled in the plan.

Qualifying Event — An event that enables an individual to make a change to their health plan outside of the enrollment period. Examples include divorce, termination of employment, or birth of a child.

Reasonable and Customary (R&C) — The prevailing charge made by physicians of similar expertise for a similar procedure in a participating geographic area; sometimes referred to as usual and customary (U&C)

Resilience — The power or ability to return to the original form, position, etc., after being bent, compressed, or stretched; elasticity. The ability to recover readily from illness, depression, adversity, or the like; buoyancy.

Risk — The possibility that costs associated with insuring a particular group will exceed expected levels, thereby resulting in losses for an insurance carrier or self-insurer.

Risk Pool — A financial arrangement that spreads the risk of utilization and cost among the participants generally the insurer, the hospitals, and the physicians. The pool may insure against unusually high utilization and costs. The pool may also provide incentives for controlling utilization and costs.

Self-Insurance or Self-Funded — Plans set up by employers who set aside funds to pay their employees' health claims. Because employers often hire insurers or HMOs to run these plans, they may look just like fully insured plans to members. Employers must disclose in your benefits information whether an insurer is responsible for funding or for only administering the plan; if the insurer is only administering the plan, it is self-insured. The U.S. Department of Labor regulates self-insured plans.

Sentinel Event — An unanticipated event in a healthcare setting resulting in death or serious physical or psychological injury to a patient or patients, not related to the natural course of the patient's illness.

Telehealth — The use of electronic information and telecommunications technologies to support and promote long-distance clinical health care, patient and professional health-related education, public health and health administration. Technologies include videoconferencing, the internet, store-and-forward imaging, streaming media, and terrestrial and wireless communications.

Trend — A persistent and pervasive change in direction over a period of time, primarily associated with medical and pharmacy costs year-over-year.

Wellness Plan / Program — An employer-sponsored program that can be part of the overall health plan or a separate program. Wellness programs aim to improve health and prevent disease while reducing overall healthcare costs, maintaining / improving employee health, and reducing illness-related absenteeism.

Glossary and Acronyms (continued)

Maximum Allowable Cost (MAC) — A list of health plans distributed to their participating pharmacies describing the maximum amount the plan will pay for specific medications.

Medicaid — Program administered by the state's Department of Medical Assistance Services (DMAS) under The Centers for Medicare and Medicaid Services (CMS). Payments are made for approved healthcare services provided by hospitals, health agencies, and private practitioners for welfare recipients or persons whose income does not exceed maximum limits. Funds are derived on a state-federal shared basis.

Medicare — The federally financed hospital insurance system (part A) and supplementary medical insurance (Part B) for the aged created by the 1965 amendment to the Social Security Act.

Medicare Part D — Also called the Medicare prescription drug benefit, is an optional United States federal-government program to help Medicare beneficiaries pay for self-administered prescription drugs through prescription drug insurance premiums (the cost of almost all professionally administered prescriptions is covered under optional Part B of United States Medicare).

Medigap (also Medicare supplement insurance or Medicare supplemental insurance) — Refers to various private health insurance plans sold to supplement Medicare in the United States. Medigap insurance provides coverage for many of the co-pays and some of the co-insurance related to Medicare-covered hospital, skilled nursing facility, home health care, ambulance, durable medical equipment, and doctor charges. Medigap's name is derived from the notion that it exists to cover the difference or "gap" between the expenses reimbursed to providers by Medicare Parts A and B for the preceding named services and the total amount allowed to be charged for those services by the United States Centers for Medicare and Medicaid Services (CMS).

Multi-Tier Networks — Multi-Tier Networks use variable network copays. The plan may include Tier A (least cost), B (average cost), and C (most cost). Employees may choose a provider at Tier A, B, or C at their point-of-need. Plan allows employees to make the consumer decision regarding perceived value and cost with every health care need.

Narrow Network — These plans have a lower premium, but as a trade-off, the choice of providers is limited. Plans must meet certain regulations, like having enough network providers in different specialties and throughout the geographic area. There must be enough providers to deliver the benefits the plan promises its members.

Network — The facilities, providers, and suppliers your health insurer or plan has contracted with to provide healthcare services.

Non-Formulary Brand Drugs—Brand name drugs that are not on the preferred drug list of the prescription drug administrator or Prescription Benefit Manager (PBM). Non-formulary drugs should be at a higher cost and less effective than equivalent drugs on the formulary list.

Non-Participating Pharmacy — A pharmacy that is not part of the retail network and does not offer a discounted rate. When you fill a prescription at one of these pharmacies, you pay for the prescription and then file a claim for reimbursement; the reimbursement amount will vary depending on your prescription drug coverage.

Open Enrollment — The period (usually once a year) during which subscribers in a health plan may have an opportunity to select an alternative plan being offered to them; or a period when uninsured employees and their dependents may obtain coverage.

Out-of-Network-Provider (Non-Participating Provider) — Any physician, hospital, pharmacy, laboratory, or other diagnostic center not under contract with a plan to provide services to members at a specified cost. In some benefit plans, members may have reduced coverage (or NO coverage if care is received from non-participating providers).

Out-of-Pocket Costs — Healthcare costs that are not covered by insurance, such as copayments, coinsurance, and deductibles.

Out-of-Pocket Maximum (OOP max or MOOP) — The maximum amount that an insured person will have to pay for covered expenses under the plan, usually within the plan effective dates.

Participating Pharmacy — A pharmacy that is part of the retail network; when you fill a prescription at one of these pharmacies, you will present your identification card and make a copayment for each covered prescription; the copayment amount will vary depending on your prescription drug coverage.

Patient Protection and Affordable Care Act (PPACA) — A law with a series of statues that go into effect beginning March 23, 2010 aimed at increasing access to affordable healthcare for most Americans. Health insurers, healthcare facilities, physicians, individuals, small and large businesses, Medicare, and Medicaid are all impacted by the law.

Point-of-Service (POS) — A form of managed care in which employees can get in-network as well as out-of-network benefits; a PCP generally manages in-network care only.

Vendor Presentations

Feedback	
What surprised you about what you heard today?	
What concerns you?	
What excites you?	
Which vendor(s) stood out to you as well aligned with SFHSS and its goals and why?	
Which vendor(s) stood out to you as not aligned with SFHSS and its goals and why?	
What would you like to hear more about from this topic?	

Notes

Scoring Today's Session	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
How much knowledge did you gain from this session?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
How much value did you gain from this session?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
How realistic is it to apply some of these ideas to the SFHSS program?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1

Specialty Topics

Feedback	
What surprised you about what you heard today?	
What concerns you?	
What excites you?	
What is SFHSS doing well in the area of member engagement?	
What could they do more of?	
How involved should SFHSS be in managing the rising drug cost?	
What would you like to hear more about from this topic?	

Notes

Scoring Today's Session	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
How much knowledge did you gain from this session?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
How much value did you gain from this session?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
How realistic is it to apply some of these ideas to the SFHSS program?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1

Glossary and Acronyms (continued)

Health Reimbursement Arrangement (HRA) — Used in reference to Consumer-Directed Health Plans. An employer sets aside a fixed dollar amount for employees to use towards their medical coverage. Once the HRA has been exhausted, the member's Bridge amount begins.

Health Savings Account (HSA) — A tax-advantaged medical savings account available to taxpayers enrolled in a high-deductible health plan (HDHP). The funds contributed to an account are not subject to federal income tax at the time of deposit.

High-Deductible Health Plan — Health plans with higher deductibles and usually lower premiums than traditional plans.

Incentives — Variations in plan design intended to change behavior.
- Positive—higher reimbursement
- Negative—benefit reduction or flat dollar penalty eligibility

Indemnity — The insurance protection against injury or loss of health; although this type of traditional system is now being replaced with other forms of insurance that share risk with providers or employers. Indemnity programs still exist to a large extent to provide reimbursement to the enrolled members for benefits under the contract. Indemnity systems reimburse on a fee for service basis for care and services.

Individual Mandate — Law that states most individuals will be required to have health insurance or pay a penalty.

In-Network Provider (Participating Provider) — Any physician, hospital, pharmacy, laboratory, or other diagnostic center under contract with the health plan to provide services to members at a specified cost.

IPA–Model HMO (Individual Practice Association; Independent Physician Association; Independent Provider Association) — Physicians form a separate legal entity, usually a corporation or partnership, which contracts with the payer / HMO to arrange care in private offices through individual contracts with member physicians in return for a negotiated fee. The IPA in turn contracts with physicians who continue in their existing individual or group practices. The individual practice association may compensate the physician on a per capita, fee schedule, or FFS basis. Represents a wholesale health care delivery component (working with a payer / HMO / retailer that markets the plan directly to employers or patients).

Knox-Keene Health Care Service Plan Act of 1975 — The set of laws or statutes passed by the California State Legislature to regulate health care service plans, including health maintenance organizations (HMOs) within the State.

Loss Ratio — The ratio of paid and incurred claims plus expenses to premium.

Mandated Benefit — A specific coverage that an insurer or plan sponsor is required to offer by law. Mandated benefits in insurance contracts can vary from state to state according to each state's insurance laws.

Mail Order Drug Program — A type of prescription drug plan where employees order maintenance medications via the mail; generally offers greatly reduced costs for prescriptions, especially for long-term therapy.

Managed Care — The concept of controlling utilization and cost of medical care by using a specific pool of providers (doctors and hospitals) to provide care.

Managed Care Organization (MCO) — A generic term applied to a managed care plan; also called HMO, PPO, EPO, although the MCO may not conform exactly to any of these formats.

Mandatory Generic — A coverage feature where an HMO requires a generic drug equivalent to be dispensed in place of a brand name drug whenever one is available. If a brand name drug is requested in this circumstance, coverage for the brand name drug may be limited, or it may not be covered by the HMO. While most HMOs require members to pay a higher copayment amount for brand name drugs, some may exclude coverage of the brand name drug or members may be required to pay a higher copayment amount for the brand name drug plus the difference in cost between the generic and the brand name.

Glossary and Acronyms (continued)

Employer Mandate — Employers with 51 or more employees must offer affordable coverage to its full-time employees or pay a penalty (created by the Affordable Care Act).

Exchange (Health Insurance Exchange) — General term for the online marketplace all states are required to have for individuals and small businesses. They serve as an Expedia or Orbitz for the health insurance market, where private insurers can offer health plans.

Fiduciary — Relating to, or founded upon, a trust or confidence. A legal term—a fiduciary relationship exists where an individual or organization has an explicit or implicit obligation to act on behalf of another person's or organization's interests in matters which affect the other person or organization. This fiduciary is also obligated to act in the other person's best interest with total disregard for any interests of the fiduciary.

First Dollar Coverage — Medical expenses covered by a benefit plan with no deductibles.

Flexible Benefit Plan — A type of benefit plan that includes employee choice, before-tax dollars, credits, and flexible spending accounts. Also called Cafeteria Plans, Section 125 Plan, and Flexible Compensation.

Flexible Spending Accounts (FSA) — FSAs give employees the opportunity to set aside pre-tax funds for the reimbursement of eligible tax-favored welfare benefits. FSAs can be funded through salary reduction, employer contribution, or a combination of both. Monies can be used to pay health insurance deductibles and copayments or pay for childcare benefits.

Formulary — A formulary is a comprehensive list of preferred brand name drug products that are covered under a given Medical Plan option. Preferred drug products are selected based on safety, effectiveness, and cost. Drugs that do not appear on this list are considered non-formulary. HMOs may offer an open formulary, a closed formulary, or an incentive formulary. Open formulary means that preferred and non-preferred drugs are eligible for the same level of coverage. Closed formulary means that only preferred drugs are eligible for coverage. Drugs not on the formulary are generally not covered. Incentive formulary means that preferred drugs and non-preferred drugs are eligible for coverage; preferred drugs will cost you less because they have a lower copayment than non-preferred drugs.

Formulary Brand Drugs — An approved list of prescription drugs. A list of selected pharmaceuticals and their appropriate dosages felt to be the most useful and cost effective for patient care. Organizations often develop a formulary under the aegis of a pharmacy and therapeutics committee. In HMOs, physicians are often required to prescribe from the formulary.

Fully Insured Plan — T he method of funding a group benefit plan whereby the employer pays an insurance company to take on claims risk.

Generic Drugs — Drugs that have the same chemical components as brand name drugs (and are certified by the U.S. Food & Drug Administration) but are marketed without a brand, using the chemical name only. Federal law requires both brand name and generic drugs to meet the same standards of strength, dosage, safety, and effectiveness. Generic drugs typically cost much less than brand name drugs and are generally considered to be equally effective.

Generic Equivalent Drugs — A drug not protected by a trademark; also, the scientific name as opposed to the proprietary, brand name. Equal in therapeutic power to the brand name originals because they contain identical active ingredients at the same doses.

Generic Requirement — Requires physicians to prescribe generic drugs when available or the cost to the patient may increase.

Genomics — The study of an individual's DNA for medical conditions and risks.

Group Health Plan — Health insurance offered by a group, typically an employer or an association.

Health Care Spending Account — Flexible benefits plan feature that permits employees to use pre-tax (tax-free) dollars from their paychecks to pay the cost of out-of-pocket health care expenses up to a certain legislated limit and within very specific guidelines.

Health Insurance Portability and Accountability Act of 1996 (HIPAA) — The law that sets standards regarding the security and privacy of person health information.

Health Maintenance Organization (HMO) — The common name given to a line of business devoted to managing populations of patients through a prepaid premium, and selling this licensed product directly (or retail) to the employer or purchaser The four types of HMO models are the group model, IPA, network, and staff model. Under the federal HMO act, an entity must have three characteristics—an organized system for providing health care or otherwise ensuring health care delivery in a geographic area, an agreed-on set of basic and supplemental health maintenance and treatment services, and a voluntarily enrolled group of patients.

Closing

Feedback	
What surprised you today?	
What would you like to hear more about?	
What do you see as SFHSS' opportunities?	
What do you see as SFHSS' barriers?	

Notes

Today's Session	
How do you feel coming out of this conversation?	

Acronyms

- **ACA** — Affordable Care Act
- **ACO** — Accountable Care Organization
- **AI** — Artificial Intelligence
- **BSC** — BlueShield of California
- **CBT** — Cognitive Behavioral Therapy
- **CDC** — Centers for Disease Control and Prevention
- **CHD** — Coronary Heart Disease
- **CMS** — Centers for Medicare and Medicaid Services
- **COBRA** — Consolidated Omnibus Reconciliation Act
- **COE** — Centers of Excellence
- **COPD** — Chronic Obstructive Pulmonary Disease
- **CPI** — Consumer Price Index
- **CSR** — Cost-Sharing Reduction (payment)
- **CY** — Calendar Year
- **DM** — Disease Management
- **DMHC** — California Department of Managed Health Care
- **DRG** — Diagnosis-Related Group
- **EAP** — Employee Assistance Program
- **EGWP** — Employer Group Waiver Program
- **ERISA** — Employee Retirement Income Security Act
- **FDA** — Federal Drug Administration
- **FSA** — Flexible Spending Account
- **FY** — Fiscal Year
- **GDP** — Gross Domestic Product
- **GOP** — Grand Old Party (Republican)
- **HAC** — Hospital-Acquired Condition
- **HAI** — Hospital-Associated Infection
- **HEDIS** — Healthcare Effectiveness Data and Information Set
- **HHS** — Health and Human Services (US Department of)
- **HIPAA — Health Insurance Portability and Accountability Act**
- **HMO** — Health Maintenance Organization
- **HRA** — Health Reimbursement Arrangement
- **HSA** — Health Savings Account
- **HSB** — Health Service Board
- **LTD** — Long Term Disability
- **M&A** — Merger and Acquisition
- **MA** — Medicare Advantage
- **MACRA** — Medicare Access and CHIP Reauthorization Act of 2015
- **MADP** — Medicare Advantage Prescription Drug
- **MHSUD** — Mental Health and Substance Use Disorder
- **MMA** — “Medicare Modernization Act” or the Medicare Prescription Drug, Improvement, and Modernization Act of 2003
- **NCQA** — National Committee for Quality Assessment
- **OOA** — Out-of-Area
- **OOP** — Out-of-Pocket
- **OTC** — Over-the-Counter
- **PCMH** — Patient-Centered Medical Home
- **PCORI** — Patient-Centered Outcomes Research Institute
- **PCP** — Primary Care Provider
- **PHI** — Protected Health Information
- **PPACA** — Patient Protection and Affordable Care Act
- **PPO** — Preferred Provider Organization
- **ROI** — Return on Investment
- **RTW** — Return to Work
- **SDOH** — Social Determinants of Health
- **SFHSS** — San Francisco Health Service System
- **SSA** — Social Security Administration
- **UHC** — UnitedHealthcare
- **VSP** — Vision Service Plan
- **YTD** — Year-to-Date

Glossary and Acronyms

Actuarial — Refers to the statistical calculations used to determine the insured rates and premiums based on projections of utilization and costs for a defined population.

Actuarial Value — The percentage of benefit costs the health insurer expects to pay toward a health plan. It is based on an average for a population or area, and may not necessarily reflect actual cost sharing.

Allowed Amount — The maximum amount on which payment is based for covered healthcare services. This may be called "eligible expense,"•"payment allowance," or "negotiated rate." If your provider charges more than the allowed amount, you may have to pay the difference..

Allowable Charge — The amount of money the insurance company will pay a non-participating provider based on that provider's geographic region.

Average Whole Price (AWP) — The published suggested wholesale price for a drug.

Brand Name Drugs — Drugs that are manufactured and marketed under a product name by a pharmaceutical company; typically, the pharmaceutical company holds a patent on the drug’s chemical components for a specified period of time.

Capitation — A capitation benefit program is one in which a provider contracts with the program’s sponsor or administrator to provide all or most of the services covered under the program to subscribers in return for payment on a per capita basis; this payment is known as a capitation fee, and it is fixed without regard to the actual number or nature of services provided to each person in a set period of time; capitation is the characteristic payment method in HMOs.

Center for Medicare and Medicaid Services (CMS) — Administrators of the Medicare and Medicaid government programs.

Centers of Excellence — A network of healthcare facilities selected for specific services based on criteria such as experience, outcomes, efficiency, and effectiveness. For example, an organ transplant managed care program, wherein member's access selected types of benefits through a specific network of medical centers.

Coinsurance — A cost-sharing requirement under a health insurance policy which provides that the insured will assume a portion or percentage of the costs of covered services; health care cost which the covered person is responsible for paying, according to a fixed percentage or amount.

Contributions — Dollar amount that enrolled employee/family is required to pay regardless of their benefit use.

Copayment — Flat dollar amount paid directly by patient.

Deductible — Flat dollar amount deducted from covered charges.
- Annual
- Per service/procedure
- Per confinement

Defined Contribution
- With **Defined Contribution**, each employee is given a check or voucher to purchase health care in the open market; the employer essentially gets out of the health care design and delivery business.
- With **Modified Defined Contribution**, the employer subsidy is fixed at current levels, or at a defined rate of increase, and employees are offered an array of options.

Disease Management — A multidisciplinary approach to managing care:
- Proactively identifies patients with or at risk for specific medical conditions
- Supports the patient-physician relationship
- Emphasizes the prevention of acute episodes, disease progression
- Utilizes cost-effective, evidence-based practice guidelines
- Encourages patient empowerment
- Continually evaluates clinical, economic, and humanistic outcomes

Drug Utilization Management (DUM) — A set of utilization management techniques for determining whether a prescribed drug therapy is the most appropriate form of therapy and also which drug is both medically appropriate and financially cost effective for the presenting condition.

Drug Utilization Review (DUR) — A review system to monitor usage of prescriptions by enrollees, to identify potential interactions with other medications, or to identify alternative-effective or cost-effective therapies.