

MEMORANDUM

DATE: February 11, 2026
TO: Supervisor Dorsey, Board of Supervisors District 6
Supervisor Chan, Board of Supervisors District 1
FROM: Rey Guillen, Executive Director, San Francisco Health Service System
RE: Letter of Inquiry, Medical Denials to City and County of San Francisco personnel by Blue Shield of California

The San Francisco Health Service System (SFHSS) is happy to provide this response to the Letter of Inquiry (LOI), dated January 29, 2026, related to “medical coverage denials to City and County of San Francisco (City) personnel by Blue Shield of California.”

Before supplying direct responses to the six specific questions contained within the LOI, SFHSS staff believe that it would be helpful to provide basic backgrounds of: 1. the differing roles and responsibilities of plan sponsors (employers) and the health plan administrators (insurance companies or third-party administrators); and 2. the general concept of injuries and illnesses presumed to be industrial among firefighters.

BACKGROUND

Roles and Responsibilities of Plan Sponsors (Employers)

All plan sponsors hold fiduciary responsibilities to prudently select and monitor the health plan administrators that provide medical coverage for its covered enrolled employees, retirees, and their eligible dependents (members). The City Charter assigns responsibility to the Health Service Board (HSB) “to adopt a plan or plans for rendering medical care to members of the system, or for the indemnification of the cost of said care, or for obtaining and carrying insurance against such costs or for such care.” Over time, the HSB has selected Blue Shield of California, Kaiser Permanente, and Health Net as current medical plans to provide a variety of options to SFHSS members.

Plan sponsors are also responsible for setting the plan terms and benefit coverage levels (in compliance with minimum coverage requirements). Every year, during its Rates and Benefits cycle, the HSB reviews the premium/administration rates and reviews the adequacy of benefit coverage of each of SFHSS’s plans, and “it may make such revisions therein as it deems equitable, but such revisions shall not become effective until approved by ordinance of the Board of Supervisors adopted by a three-fourths of its members.”

In California, plan sponsors, including SFHSS, are generally only allowed to receive limited, aggregated, or anonymized health claims data for administering the health plan they offer to their employees. Plan sponsors are prohibited from accessing detailed, individually identifiable medical records, without specific authorization, to comply with privacy laws like the Health

Insurance Portability and Accountability Act (HIPAA) and the California Privacy Rights Act (CPRA).

Roles and Responsibilities of Health Plan Administrators/Third Party Administrators

Health plan administrators (Plans) are typically responsible for reviewing requests for care, issuing approvals or denial determinations based on the plan's coverage terms. They also process claims for plan participants in accordance with the official plan documents and medical necessity. When denying, modifying, or delaying care, Plans must provide specific reasons, often based on medical necessity or experimental guidelines.

Through the normal course of health plan operations, Plans may deny claims for a variety of reasons; common denial reasons include incomplete or inaccurate documentation, services not covered under the policy (i.e. excluded from coverage), treatment deemed not medically necessary, use of out-of-network providers (for HMO plans), or elapsed submission deadlines. A January 2025 study by the Kaiser Family Foundation¹ found that medical insurance companies that offered qualified health plans sold on HealthCare.gov denied 19% of in-network claims in 2023 and 37% of out-of-network claims for a combined average of 20% of all claims. The same study found that, for participating insurers submitting complete 2023 claims data to Covered California, the in-network denial rate was 21%. However, this does not necessarily point to an underlying effort by Plans to prevent access to medically necessary care. A significant number of claim denials normally result from minor clerical errors by medical provider offices, such as inaccurate/missing documentation or incorrect billing codes. Following receipt of such denials, provider offices are normally able to quickly correct and resubmit the denied claims, actions which most often result in the amended claim being approved and processed without significant delay.

Understandably, receiving a claims denial can be frustrating to our members and their loved ones. However, taking the time to understand the denial is the first step a member should take. The member should carefully review the denial letter and the applicable plan documents to determine why the claim was denied and whether the decision was valid.

If the member believes a denial was issued incorrectly, they always have the right to file an appeal. All plans are required to offer a formal appeals process, providing a full and fair review of denied claims and/or requests for services. Each Plan that SFHSS manages has a slightly different formal appeals process, depending on the regulatory agency which oversees the plan, including internal reviews and the option to request an independent, external review if needed. However, due to the medical privacy concerns highlighted above, SFHSS is generally excluded from participating in any part of such appeals processes.

As mentioned above, SFHSS's medical plans may be overseen by a regulatory agency that is responsible for enforcing regulations against unnecessary claim denials, or other non-resolved Plan grievances members may experience. The California Department of Managed Healthcare (DMHC) oversees SFHSS's Health Maintenance Organization (HMO) plans. California

¹ <https://www.kff.org/private-insurance/claims-denials-and-appeals-in-aca-marketplace-plans-in-2023/>

requires insurers to report data on claims received and denied each year for both in- and out-of-network services.

Further, SFHSS's Medicare Advantage HMO and PPO plans are overseen by the Centers for Medicare and Medicaid Services (CMS). Medicare Advantage plans, like SFHSS's Blue Shield Medicare Advantage with Prescription Drug (MAPD) and Kaiser Permanente Senior Advantage (KPSA) plans, are required to cover everything that Original Medicare covers. Likewise, all Medicare Advantage plans must also follow the federal rules set forth by CMS, which include guidelines like restricting plans from covering any medical/surgical procedures, equipment, or medications determined by Original Medicare to not be generally accepted by the medical community, unless covered by Original Medicare under a Medicare-approved clinical research study. Plans are also prohibited from covering any drugs that have not been approved by the Food and Drug Administration for the specific condition being treated (off-label use). Failure to comply with these regulations can lead to CMS penalties, including fines, suspension of marketing/enrollment, or contract termination.

Cancer Presumption for Firefighters

The LOI draws attention to the occupational cancer risks of firefighters and the statutory presumptions that apply. In California, a cancer presumption for firefighters (Labor Code Section 3212.1) means that cancer developing or manifesting during employment is legally presumed to be caused by the job, shifting the burden of proof from the firefighter to the employer to prove otherwise. This allows firefighters to receive workers' compensation benefits, including medical treatment, disability, and death benefits. The cancer presumption applies for up to ten (10) years from the last day the firefighter worked depending on the length of service. For every year of service the firefighter had, the firefighter accrues three (3) months for the cancer presumption.

Workers' compensation and employer-provided health plan coverage, such as the plans managed by SFHSS, are distinct systems: workers' compensation covers work-related injuries (medical costs and lost wages) with no employee cost, while health insurance covers general, non-work-related medical needs. When injured on-the job, workers' compensation takes precedence and covers 100% of reasonable and necessary medical care for job-related injuries.

SFHSS sponsored medical plans generally are responsible for off-the-job injuries, illnesses and general health. The premiums that are set for employer-sponsored health plans are not set at a level to cover work-related injuries, as it does not cover them.

LOI QUESTIONS AND SFHSS RESPONSE

1. Broadly, since January 1, 2025, is there evidence to suggest that Blue Shield of California may be engaging in post-claim underwriting practices to deny medically necessary treatment to city workers and retirees?

SFHSS Response – No. While SFHSS has received reports of denials, SFHSS has not received any reports where Blue Shield has denied requests for care that is considered

medically necessary or where Blue Shield failed to pay claims for care that is included in SFHSS's plan documents that would suggest to SFHSS that Blue Shield is deliberately denying eligible claims.

This question introduced the phrase “post-claim underwriting practices.” Although we understand that the question is generally asking if SFHSS has seen any indication that Blue Shield is purposely denying otherwise eligible claims for extraneous reasons, “post-claim underwriting” is a practice, most frequently associated with individual, small-group health insurance, or life insurance policies, where insurance companies only review or investigate an applicant's health history or risk factors after a claim is filed, rather than before issuing a policy. Insurers often used this to find inaccuracies in the original application, allowing them to deny coverage or cancel the policy to avoid paying large claims. Since group health plans, such as those administered by SFHSS, cannot refuse coverage or charge more due to pre-existing conditions this practice would generally not be applicable.

2. How does Blue Shield's record of denials for 2025 compare to the record of denials by UnitedHealthcare for retirees with their MAPD PPO plan for the 2024 plan year, or other earlier years?

SFHSS Response – Due to the medical privacy rules outlined above, SFHSS does not receive records of denials from Blue Shield. Similarly, SFHSS did not receive such a record of denials from UnitedHealthcare for the years it administered the SFHSS MAPD PPO plan (2016 – 2023). Therefore, SFHSS cannot perform the requested comparison.

3. Please provide information, to the extent possible, on how many cancer-treatment requests submitted on behalf of current or retired San Francisco firefighters have been denied, partially denied, or delayed by Blue Shield.

SFHSS Response – Again, due to the medical privacy rules outlined above, SFHSS does not receive records of denials related to requests for care from any of its sponsored medical plans. Furthermore, SFHSS does not supply its members' occupations to its plan administrators since the benefit coverage provided is the same for all members (active employees, retirees, and their covered dependents).

4. How do denial and appeal rates for firefighter cancer cases compare to those of other SFHSS members with cancer diagnoses?

SFHSS Response – SFHSS does not provide data to SFHSS sponsored Health Plans, which would disclose the job/position held by its members. Due to the medical privacy rules outlined above, Blue Shield medical plans do not provide records of denials or appeals to any of their clients. Since SFHSS does not supply its members' occupations to its plans, completing such a comparison is not possible.

5. What are the average timelines for initial determinations and appeals in firefighter cancer cases, and how does Blue Shield ensure that delays do not jeopardize patient outcomes?

SFHSS Response – The turn-around times for coverage determinations do not differ based on a members current or prior occupation with the City. Furthermore, SFHSS does not supply its members' occupations to its plan administrators.

For the SFHSS Blue Shield MAPD PPO plan, a standard coverage decision is usually made within seven (7) calendar days when the medical item or service is subject to the plan's prior authorization rules, fourteen (14) calendar days for all other medical items and services, and seventy-two (72) hours for Medicare Part B drugs. A member may ask for a fast coverage decision for coverage for medical items and/or services when the standard coverage decision timeline could cause serious harm to the member's health or hurt the member's ability to regain function. A fast coverage decision means Blue Shield will answer within seventy-two (72) hours if the member's request is for a medical item or service, and within twenty-four (24) hours if the member's request is for a Part B drug.

6. In light of cases now coming to light, are you aware of any steps Blue Shield is currently taking to review its practices and ensure firefighters and other city workers and retirees receive timely access to medically necessary care?

SFHSS Response – SFHSS staff have reviewed all the cases included in the original letter of inquiry, including the case of retired firefighter Ken Jones, to the extent possible and in compliance with medical privacy rules. This review included calling the member when available, requesting a medical release of information when necessary, and requesting the member's medical claim history from Blue Shield, if authorized.

In the cases introduced through this LOI in which we were able to receive member information, SFHSS has evidence that Blue Shield administered timely access to medically necessary care. SFHSS has determined that the denials were appropriate for the situation, and followed the appropriate processes as outlined in the plan documents. Further, it has been determined that any original denials and Plan responses to associated appeals were completed within required timelines.

SUMMARY

The San Francisco Health Service System has not received any indication that any of its health plan administrators have acted in bad faith, such as unreasonably delaying, misrepresenting plan terms, or denying valid claims. After careful review of Mr. Jones' case, we determined that Blue Shield did not withhold appropriate care, in accordance with CMS coverage guidelines for experimental or investigational treatments. Denials related to lack of medical necessity or Food and Drug Administration (FDA) approval for the specific medical condition would have occurred at any Medicare Advantage plan, regardless of whether the plan was administered by UnitedHealthcare or Blue Shield.

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In the case of Ken Jones, his provider originally requested authorization for ten (10) separate drugs; seven (7) were approved by Blue Shield, and three (3) were denied. Those three (3) were denied because the medications have not been approved by the FDA for Mr. Jones' specific medical condition, and they all lack medically accepted off-label use, supported by CMS.

Mr. Jones' medical provider submitted an expedited reconsideration request (appeal) to Blue Shield. This was forwarded to Blue Shield's Advanced Medical Reviews (AMR) team for clinical peer review, and the initial denial was confirmed. Mr. Jones' provider then requested a review by an Independent Review Entity (IRE) that works for CMS (the regulatory agency), not Blue Shield. The IRE, Maximus, upheld the denial. All of this was handled as an expedited appeal, with the entire process being completed within ten (10) calendar days of the original authorization request. On 1/12/2026, a new treatment regimen was submitted by Mr. Jones' provider and approved by Blue Shield on that same day.

SFHSS holds the deepest appreciation for the brave men and women of the San Francisco Fire Department and for the families who stand beside them. We believe that they deserve the equitable, sustainable, and quality benefits that we make it our mission to provide to all our members. Please rest assured that we would be the first to raise a red flag if we ever received an indication that any one of our health plan vendors were failing to provide the benefits coverages they have been contracted to provide.

San Francisco Health Service System