PROBLEM WITH BLUE SHIELD

To Supervisors Chan, Dorsey and Sauter:

I am Herbert Weiner, a retired Senior Social Worker, who served the City and County of San Francisco from 1964 to 2003.

Preesently, I reside in assisted living and am recovering from aortic stenosis which was remedied by a valve replacement procedure at UCSF which was life saving; rehabilitation services, authorized by Blue Shield, were required after the surgery and hospitalization.

Prior to hospitalization at UCSF, where the valve replacement procedure was performed, I was hospitalized at California Pacific Medical Center Bernal Heights Campus for a neurogastric virus and was discharged to the Center for Jewish Living rehabilitation services. Because my blood pressure was low, I was readmitted to UCSF shortly after and, after discharge from UCSF, was back at the Center for Jewish Living.

Because of the possibility of readmission to the hospital, as noted above, a thorough review by the staff of UCSF would seem appropriate. Blue Shield wished to discharge me, independent of collaboration with the UCSF physicians. Due to this, an appeal was filed.

Without the appeal being resolved, I was discharged from rehab.

This seems to indicate that the decision of Blue Shield, not my physicians, has precedence over medical decisions.

Fortunately, I do not require readmission which would be taxing on me.

Shouldn’t the appeal have been resolved, prior to my discharge?

The impression I get from my experience is that Blue Shield places money and profit over the lives and medical well being of their members.

Are they glorified claims adjusters who place dollars over services?

This is a question that the three of you must answer.

From:	Teresa Palmer
To:	Jalipa, Brent (BOS); Chan, Connie (BOS); Burke, Robyn (BOS); DorseyStaff (BOS); Dorsey, Matt (BOS); Dahl, Bryan (BOS); Sauter, Danny (BOS); SauterStaff; Lee, Amy (BOS)
Cc:	Guillen, Rey (HSS); Health Service Board (HSS); Lopez, Holly (HSS)
Subject:	SF BOS Budget and Finance Comm: Agedna Item #8--File # 260202- Blue Shield Denial of Care for City Retirees-
Date:	Saturday, April 4, 2026 11:52:30 AM

This message is from outside the City email system. Do not open links or attachments from untrusted sources.

Date April 4, 2026
From:
Teresa Palmer M.D, SF City and County Retiree with Blue Shield/Medicare
1845 Hayes St.
San Francisco California 94117
phone 415-260-8446. email: teresapalmer2014@gmail.com

Re; Budget and Finance Committee Hearing Weds April 8 10 a.m-Agenda Item #8, file number 260202

To:
Clerk of SF BOS Budget and Finance Committee: Please file this letter and assist me in bringing it to the attention of the Budget and Fianance Committee.
Brent Jalipa
Email: Brent.Jalipa@sfgov.org
(415) 554-7712

Committee Members:

Supervisor Connie Chan Connie.Chan@sfgov.org
Robyn.Burke@sfgov.org
chanstaff@sfgov.org | (415) 554-7410

Supervisor Matt Dorsey Matt.Dorsey@sfgov.org
bryan.dahl@sfgov.org
DorseyStaff@sfgov.org

Supervisor Danny Sauter Danny.Sauter@sfgov.org
Amy.Lee5@sfgov.org
SauterStaff@sfgov.org

Agenda Item # 8. FILE NUMBER = 260202
LINK TO FILE NUMBER: https://sfgov.legistar.com/LegislationDetail.aspx?ID=7933688&GUID=09DBDD47-9354-4B4A-A0CB-84A938DF8907
[Hearing - Blue Cross Blue Shield of California Insurance Denial of Care]
Sponsors: Chan; Dorsey Hearing on the denial of health care, including cancer care for San Francisco workers, retirees and their families by Blue Shield; and requesting the San Francisco Health Services Board, Blue Cross Blue Shield of California, and Protect our Benefits to report.

Date. April 4 2026. **Testimony: Denial of Medications essential for treatment**

As a city retiree who is eligible for Medicare, I am insured under Blue Shield "Medicare PPO". That gives Blue Shield the power to say what will be paid for, even if, under traditional Medicare (which would only pay 80% of the bills), Medicare would pay for a given test, treatment or drug.

I had a total knee replacement on March 16 2026. As a victim of auto-immune inflammatory arthritis, this was one of 4 major surgeries to stabilize my bones and joints that I have had over 30 years. After a joint replacement like this, the patient is required to do painful range of motion exercises (supervised by physical therapy) beginning immediately after surgery so full function (in this case walking and climbing stairs) can be achieved as the native tissues heal around the artificial joint.

For past surgeries, I have always used a combination of short and long acting narcotics in the post-operative period--in my case Oxycodone (which alone is effective only for 3-4 hours), and Oxycontin -the long acting version, which is effective for 8-12 hours.

Using the short acting medication alone means that one must either use very frquent doses to control the pain (interfering with sleep and giving only a short interval between freedom from pain and rapidly increasing pain). Adding 2 doses a day of the "long acting" version mean many more hours of pain control without peaks or valleys. This predictably allows the patient to succeed in rehab, to sleep without awakening in agony.

It is not a coincidence that the long acting pain medication (oxycontin) is expensive--with a cost of about $600 for 40 pills.

Blue Shield refused to pay for Oxycontin (long acting) due to a guideline the insurance company had dug up that "Oxycontin is not indicated for acute post operative pain." In fact, these are guidelines, and every operation and patient is different. The treating physician is free to use the drug "off label" if in an individual case, the patient will benefit. However, to get the insurance company to pay, ("prior authorization")the surgeon is required to fill out endless appeals with repetitive questions that have little to do with the needs of the individual patient. This results in repetitive denials for exactly the same reason the drug was originally denied. The insurance company is patently not interested in knowing the doctor's clinical opinion about what is best for the patient.

Neither my doctors office nor I had the time or ability to jump through Blue Shields hoops, so after many phone calls (by both myself and the physician's staff) and much time on hold, I paid my pharmacy hundreds of dollars for that prescription, and then had to do it all over again when I required a refill. Meanwhile, both my doctors' staff and I were emailed, faxed and otherwise told to go on line to get endless complicated forms---but no form resulted in a change in the insurance companies' determination not to pay.

Imagine my surprise AGAIN when Blue Shield ALSO denied a refill of my short

acting pain med, Oxycodone, on the basis of a mysterious quantity limit. No one could tell me or my doctors' assistant what the quantity limit actually was, and they wanted to speak to the doctor, a busy surgeon, himself. As far as I can tell, the doctor and his staff, did the best they could for me, but finally gave up, after calling me to be sure I was able to pay.

So, with my rehab and healing at stake, I again paid out of pocket for the short acting oral narcotic.

My concern is not so much for myself, but for others who are less economically privileged than I am: The course of rehabilitation from knee replacement is one to the most painful and prolonged of all joint replacements. **Blue Shield is practicing medicine without a license: dictating severe constraints on pain relief, while going against the clinical judgement of the treating physician.**

In the case of a knee replacement, if good range of motion is not achieved in the first month post op, it will never be achieved without further surgery. SO for someone who is forced to take far too few narcotic pain meds, they may either be required to have further painful surgery ("manipulation under aneasthesia") or without the surgery- to limp and go down stairs one foot at a time for the rest of their lives.

This is unacceptable. Lower income cIty retirees are unreasonably consigned to preventable pain and suffering either due to denial of treatment (while BS insists on appeals that are so time consuming that the medications cannot be delivered to the patient in time), or by forcing the patient to pay out of pocket.

I am asking the Committee and the Health Services Board to stop this practice by Blue Shield, and ones similiar to it,for the well being of city retirees.

While this example is not a refusal to pay for cancer treatment, which can result in death---**it is a refusal to pay for treatment that may leave the patient with a permanent and preventable disability. How can this be allowed?**

Health Services Board: I am happy to waive my HIPAA privacy rights in order to help others--please do not use the excuse of "patient confidentiality" to avoid pursuing this.

Thank you, Teresa Palmer M.D.