File No. 130653 Committee Item No. 12
Board Item No. 35

COMMITTEE/BOARD OF SUPERVISORS

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Committee: Budget and Finance Sub-Committee **Date:** 07/17/2013

Board of Supervisors Meeting **Date:** July 23, 2013

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Completed by: Victor Young **Date** July 12, 2013
Completed by: Victor Young **Date** 7/18/13

FILE NO. 130653 ORDINANCE NO.

[Administrative Code - Health Service System Plans and Contribution Rates - Calendar Year 2014]

Ordinance amending the Administrative Code, Chapter 16, Article XV, of Part 1, Section 16.703, regarding Board approval of health service system plans and contribution rates for calendar year 2014.

Note: Additions are *single-underline italics Times New Roman*; deletions are ~~*strikethrough italics Times New Roman*~~. Board amendment additions are double underlined. Board amendment deletions are ~~strikethrough normal~~.

Be it ordained by the People of the City and County of San Francisco:

Section 1. The San Francisco Administrative Code is hereby amended by amending Section 16.703, to read as follows:

Sec. 16.703 HEALTH SERVICE SYSTEM; PLAN AND CONTRIBUTION RATES.

Changes in contribution rates adopted by the Health Service Board, as respect~~s~~ *to* the plans of the Health Service System, to become effective on ~~*January 1, 2013*~~ *January 1, 2014* for the calendar plan year January 1, 201~~*3*~~ through December 31, 201~~*3*~~, approved by the Health Service Board in actions taken by it on *June 13, 2013*~~*April 12, 2012, May 10, 2012, June 1, 2012, June 14, 2012 and July 3, 2012*~~, which plans and contribution rates are on file with the Clerk of the Board of Supervisors, are hereby approved.

APPROVED AS TO FORM:
DENNIS J. HERRERA, City Attorney

By: _____ for
Erik Rapoport
Deputy City Attorney

Items 12 and 13 Files 13-0653 and 13-0654 *(Continued from July 10, 2013)*	Department Health Service System (HSS)

EXECUTIVE SUMMARY

Legislative Objectives

- The proposed ordinance (File 13-0653) would amend Administrative Code Section 16.703, establishing the Health Service System's 2014 health, vision, and dental plans and premiums.
- The proposed resolution (File 13-0654) would approve the 2014 employers' contribution of $559.65 per member per month to the Health Service System Trust Fund.

Fiscal Impacts

- In accordance with the City's Charter, the Health Service Board is required to conduct a survey of the ten most populous California counties each year to determine the average of the health premium contributions made by the ten counties. Based on this survey, the average 2014 contribution is $559.65 per member per month, which is $24.87 or 4.65 percent more than the ten-county average contribution of $534.78 in 2013.
- However, the City's monthly health premium contributions for employees is proposed to be (a) $1,046.99 for the City's Health Plan, a 16.84% reduction, (b) $562.30 for Kaiser, a 4.71% increase, and (c) $612.56 for Blue Shield, a 5.3% reduction.
- The total costs for the City, employees, retirees, and their dependents of $595,803,151 in 2014 for health, vision, dental, long-term disability and life insurance, is $4,054,015, or 0.7 percent more than the $591,749,136 costs for these plans in 2013.
- Of the total 2014 costs of $595,803,151, the City's costs (excluding employee or retiree contributions) are $523,163,928, or approximately 87.8 percent of the total costs.
- Health premiums in 2014 will be increased by federal fees and taxes from legislation including the Patient Protection and Affordable Care Act.
- Health premium contributions in 2014 will be affected by cost-sharing agreements that were negotiated between the City and various City unions in 2012.

Recommendations

- Approve the proposed ordinance (File 13-0653) to amend Administrative Code Section 16.703, establishing the Health Service System's 2014 health, vision, and dental plans and premium contribution rates.
- Approve the proposed resolution (File 13-0654), setting the City's 2014 average contribution to the Health Service System Trust Fund under Charter Section A8.428 in the amount of $559.65 per member per month.

MANDATE STATEMENT/BACKGROUND

The Health Service Board oversees the Health Service System (HSS). The HSS administers non-pension benefits, including health, dental, vision, and other benefits that may be available to City employees, such as life and long term disability insurance.

The Health Service Board adopts the annual health, vision, and dental plans, and the respective plan premiums and premium equivalents paid by employers and members.

- HSS employers include the City and County of San Francisco (City), the San Francisco Unified School District (SFUSD), the San Francisco Community College District (SFCCD), and the San Francisco Superior Court (Superior Court).
- HSS members are active and retired employees of the above noted employers, their dependents, and members of eligible boards and commissions. Dependents include children, spouses, domestic partners, surviving spouses of deceased members, and other legal dependents.

Under City Charter Section A8.423, the Health Service Board is required to (a) conduct a survey of the ten most populous California counties each year, excluding San Francisco, and (b) determine and set the health plan premiums paid by the City, employees, and retirees. In accordance with Section A8.423 of the City's Charter, the City's contribution to the Health Service System Trust Fund is based on the average of the contributions made by each of the ten counties.

The 10-County "average contribution" in 2014 is $559.65, which is $24.87 or 4.65 percent more than the 10-County "average contribution" of $534.78 in 2013.

DETAILS OF PROPOSED LEGISLATION

File 13-0653: The proposed ordinance would amend Administrative Code Section 16.703 to approve the Health Service Systems' 2014 health, vision, and dental plans and premiums, and life insurance and long term disability insurance.

File 13-0654: The proposed resolution would approve the City's 2014 contribution to the Health Service System Trust Fund, under Charter Section A8.4289, at $559.65 per member per month.

Proposed Health Plans

On June 13, 2013, the Health Service Board approved the subject health, vision, and dental plans and monthly premiums for 2014 as follows:

City Plan Preferred Provider Organization (PPO)[1]

The City Plan is a self-funded plan administered by United HealthCare (UHC). The Health Service Board adopted no plan design changes to the City Plan in 2014.

Kaiser and Blue Shield Health Maintenance Organizations (HMO)[2]

Consistent with the 2013 plan year, two HMOs will be offered to HSS members for the 2014 plan year; Kaiser and Blue Shield of California. The Blue Shield HMO plan is a flex-funded product for active and early retiree members. The Health Service Board adopted no plan design changes to the Kaiser HMO or the Blue Shield HMO.

Vision Plans

Members enrolled in one of the three health plans receive vision benefits through Vision Service Plan (VSP), a third party insurer. The VSP plan is a fully-insured plan. The 2014 rates will increase 5.5% which includes 2% due to federal healthcare reform taxes. The cost of the vision plan is added to the cost of the medical plan for all monthly health plan premiums.

Sources of Health Plan Premium Increases

The following two major changes will affect health plan premiums and the payment of these premiums in 2014.

(1) The premiums covered by the employer for each health plan will vary according to union membership of the covered employee as per negotiated Memorandum of Understanding (MOU) agreements (please see section entitled, 'Changes in Contribution Strategy', below).

(2) Federal healthcare reform will add fees and taxes to the premium calculation (please see section entitled, 'Impacts of Federal Legislation', below).

According to Mr. Gregg Sass, Interim CFO at HSS, all other changes in premiums are a result of health plan premium increases and/or savings from under-utilization.

Changes in Contribution Strategy

Changes in City and County (CCSF) Contribution Strategy

Historically, active CCSF employees have paid nothing for employee-only health and dental insurance coverage. Starting January 1, 2014, in accordance with some union MOU agreements[3],

[1] Under a PPO, physicians, hospitals, and other providers contract with a third-party administrator or insurer to provide health care at reduced rates to members.

[2] An HMO offers care through a closed panel of providers, in which members select a primary care physician, who coordinates care to direct access to medical services.

[3] According to Mr. Sass, this negotiated change would impact approximately 7,800 employee-only members, which is approximately 70% of active employee-only members, by July 1, 2014. The Health Service Board approved two sets of rates to reflect this change in 2014. One set of rates is for members under this new '90/10 Contribution Model', and the other set of rates is for members under the existing contribution model.

the employee contribution amount will increase to a maximum of 10 percent of the premium. This contribution calculation is called the '90/10 Contribution Model'.

Under the '90/10 Contribution Model', the City will contribute the greater of the 10-County average amount ($559.65) or 90 percent of the employee-only premium for active employees in the Kaiser and Blue Shield populations. For active employee-only members in the City Plan, the City will contribute 90 percent of the Blue Shield employee-only premium plus one-half of the difference between 90 percent of the Blue Shield employee-only premium and 100 percent of the City Plan employee-only premium. This change applies only to those employees that do not have dependent coverage.

The City Charter states, in Section A8.423, "the average contribution made with respect to each employee by said 10 counties toward the health care plans provided for their employees ... **shall be 'the average contribution'**." According to Mr. Jon Givner, Deputy City Attorney, the Charter provides the amount that must be contributed to the Health Service System Trust Fund by the City, but that amount is not a ceiling and the City could agree to pay additional amounts to fund employee health care under an MOU with a union representing City employees.

HSS Subsidy Option

On June 14th, 2013, the Health Service Board approved another set of rates for any union that approves an MOU agreement with the City by July 31, 2013 for a different (flat premium) employee contribution amount for 2015. This flat premium would reflect a trust-funded subsidy for the employee-only employee contribution amount under the '90/10 Contribution Model'. The subsidy would smooth member transition to the 2015 contribution model. Unlike the '90/10 Contribution Model', which applies to employee-only members in Blue Shield and the City Plan only, the flat premium would apply to all members of all three plans, including Kaiser. Participation would be broader but the required contribution by individual members would be lower than under the '90/10 Contribution Model'. The San Francisco Department of Human Resources is currently involved in MOU negotiations to define the specific rates for this subsidy option.

City's Monthly Premium Costs

As previously noted, the 10-County average determined that the City contribution to the Health Service System Trust Fund in 2014 would be $559.65 per month. However, Table 1 below shows a "blended" rate for each of the three health plans for 2014 which is a weighted calculation of the City's contribution payment for active employees based on the proportion of employees subject to the '90/10 Contribution Model' versus the proportion of employees subject to the original rate schedule.

Table 1
Total Monthly Employer Rate for Active Employees in 2014

	2013	2014 Proposed	Increase	Percent Change
City Health Plan	$1,258.97	$1,046.99	($211.98)	(16.84%)
Kaiser	$537.02	$562.30	$25.28	4.71%
Blue Shield	$647.16	$612.56	($34.60)	(5.35%)

Proposed Health Plan Premiums

City Health Plan Premiums

The City Health Plan is self-funded. Amounts to cover premiums are deposited into the Health Service System Trust Fund and used to pay claims. Monthly premium amounts are based on claims experience for each type of plan member: active employees, retirees with Medicare, and retirees without Medicare.

The blended monthly employer rate, or amount that the City will pay, for single employees will decrease by 16.84 percent in 2014, as shown above in Table 1. This decrease is because of utilization savings in prior years, which appears as a rate reduction in 2014.

Under the City Health Plan, employee premiums will decrease in 2014 by approximately 2.7 percent overall, mainly because of prior-year utilization savings and the '90/10 Contribution Model'.

Kaiser Premiums

The Kaiser Plan blended monthly employer rate for single employees will increase in 2014 by 4.71 percent, as shown in Table 1 above. Under the Kaiser plan, employee premiums will increase in 2014 by approximately 5.2 percent overall. These premium increases reflect new federal healthcare reform as well as administrative cost increases at Kaiser.

Blue Shield Premiums

The Blue Shield Plan blended monthly employer rate for single employees will decrease by 5.35 percent in 2014, as shown in Table 1 above. This is because of the '90/10 Contribution Model' and slightly lower average utilization than expected. Under the Blue Shield plan, employee premiums will stay flat in 2014 except for retiree premiums, which will increase by approximately 6 percent because of federal healthcare reform and health cost increases.

Proposed Dental Plans

The Health Service System offers three dental plans, including one PPO, Delta Dental PPO, and two HMOs: Delta Care USA and Pacific Union Dental. There are no plan changes in the dental plans.

The City does not contribute to the monthly dental premium for retired employees. The City contributes the full monthly premium for active employees for the two HMOs and also

contributes part of the monthly premium for active employees for Delta Dental PPO. As shown in Table 2 below, the City's contribution to premiums will increase up to 4.2% in 2014 for all dental plans except for Pacific Union Dental, whose premiums remain unchanged from 2013.

Table 2
Total Monthly Dental Premiums

	2014	2013	Increase/ Decrease	Percent
Delta Care USA HMO				
Single Employee	$26.95	$26.00	$0.95	3.7%
Employee + One Dependent	$44.46	$42.90	$1.56	3.6%
Employee + Two or More Dependents	$65.76	$63.45	$2.31	3.6%
Pacific Union Dental HMO				
Single Employee	$27.80	$27.80	$0.00	0.0%
Employee + One Dependent	$45.90	$45.90	$0.00	0.0%
Employee + Two or More Dependents	$67.86	$67.86	$0.00	0.0%
Delta Dental PPO				
Single Employee (Total Premium)	$65.95	$63.47	$2.48	3.9%
Less Employee Contribution	($5.00)	($5.00)	$0.00	0.0%
City's Contribution	$60.95	$58.47	$2.48	4.2%
Employee + One Dependent (Total Premium)	$138.49	$133.29	$5.20	3.9%
Less Employee Contribution	($10.00)	($10.00)	$0.00	0.0%
City's Contribution	$128.49	$123.29	$5.20	4.2%
Employee + Two or More Dependents (Total Premium)	$197.84	$190.42	$7.42	3.9%
Less Employee Contribution	($15.00)	($15.00)	$0.00	0.0%
City's Contribution	$182.84	$175.42	$7.42	4.2%

Contingency and Stabilization Amounts

The HSS sets aside a portion of the Trust Fund balance[4] to provide contingencies for the self-funded dental plan, Delta Dental PPO, and to stabilize employees' dental plan premium increases. The member contributions for Delta Dental PPO plan for retirees, Delta Care USA dental plans for employees and retirees, and Pacific Union Dental plans for employees and retirees remain unchanged from the prior plan year. Pursuant to the Health Service's Self-Funded Plans' Funding Policy, no claims stabilization amount has been applied this year.

Life and Long Term Disability Insurance

The Health Service System will continue its contract with Aetna Life Insurance Company in 2014. In January 2013, Aetna Life Insurance Company was selected through a Request for Proposal (RFP) process to provide life and long term disability insurance to City employees eligible for coverage through their MOUs between the City and the respective unions.

[4] The Employee Benefit Trust Fund is funded via payroll deductions and employer contributions. Those amounts are paid into the Trust Fund and premiums are paid by the Trust Fund. The fund balance is what remains after accruing all liabilities for unpaid premiums and incurred but not reported expenses of self-insurance programs. As of June 30, 2012, the fund balance in the Trust Fund was $53.2M, which is projected to increase to $69.5M by June 30, 2013.

Impacts of Federal Legislation

As of January 1, 2014, a provision of the Federal Patient Protection and Affordable Care Act (PPACA) will take effect, introducing the Federal PPACA Legislative Fees. Implementation of another provision previously scheduled to take effect in 2014, the Federal PPACA Full Time Employee requirements, has been deferred by the federal government until 2015. Both of these provisions are briefly summarized below. Implementation of an additional provision, Federal PPACA Automatic Enrollment, has also been deferred because the Department of Labor stated that it will not issue final guidance on Automatic Enrollment until 2014. In addition to Federal PPACA requirements, the 2009 American Recovery and Reinvestment Act established a temporary Early Retiree Reinsurance Program (ERRP), also summarized below.

Federal PPACA Full Time Employee requirements

A current assessment by HSS indicates that no additional payments will be incurred under this federal legislation because both the City and the Superior Courts offer coverage to all full time employees. HSS is still working with the San Francisco Community College District (SFCCD) and the San Francisco Unified School District (SFUSD) and to assess their compliance with federal PPACA requirements. On July 2, 2013 this PPACA requirement was deferred until 2015.

Federal PPACA Legislative Fees

As a result of the federal PPACA, there are two direct fees and one tax that have been factored into the calculation of medical premium rates and premium equivalents for the 2014 plan year. The three fees are the Health Insurer Tax (HIT), Patient Centered Outcomes Research Institute (PCORI) fee, and the Transitional Reinsurance fee. Table 3 (below) summarizes the estimated cost of each of these legislative fees for 2014 for the City and County of San Francisco.[5]

Table 3
Federal PPACA Legislative Fees and Taxes ($ Millions) in 2014

	HIT	PCORI	Transitional Reinsurance	**Total**
City Plan (UHC)	$0.00	$0.01	$0.13	**$0.14**
Kaiser	$2.15	$0.09	$2.10	**$4.33**
Blue Shield	$6.27	$0.07	$1.91	**$8.26**
Delta	$0.00	N/A	N/A	**$0.00**
VSP	$0.07	N/A	N/A	**$0.07**
Total	**$8.49**	**$0.18**	**$4.13**	**$12.80**

[5] The HSS Trust Fund serves four employers: The City and County of San Francisco, the Superior Courts, San Francisco Community College District and the San Francisco Unified School District (CCSF, CRT, SFCCD, and SFUSD). The costs shown in Table 3 reflect only those PPACA charges incurred by CCSF.

Early Retiree Reinsurance Program Reimbursements

The 2009 American Recovery and Reinvestment Act established the temporary Early Retiree Reinsurance Program (ERRP) as an incentive for employers to continue early retiree health insurance coverage. This program provided federal reimbursement to eligible sponsors of employment-based plans for a portion of the costs of providing health coverage to early retirees, during the period beginning on the date the program was established, and ending on December 31, 2013. The total ERRP amount received by HSS from the federal government with interest is $3,812,749. A plan sponsor may use these ERRP reimbursements to reduce the sponsor's health benefit premiums or costs, to reduce costs for plan participants, or to reduce any combination of these costs.

However, ERRP regulations stipulate a Maintenance of Contribution (MOC), requiring that the City continue to provide at least the same level of contribution to support each plan if any of the reimbursement funds are used to offset City costs, rather than exclusively used to offset employee contributions.

On January 10, 2013, the Health Service Board approved spending the ERRP reimbursement funds exclusively to reduce participant premium contributions in order to decrease both participant and employer premiums through stabilizing membership and premium rates, which will allow HSS to bypass the MOC calculation requirements. The Health Service Board also approved apportioning the ERRP reimbursement funds based on the amount of premiums paid into each plan in proportion to each set of rates paid in 2013.

FISCAL ANALYSIS

The City's cost for health and other plans is funded by charges to each City Department for the cost of employee benefits.

As shown in Table 4 below, the total City, employee, and retiree costs for the health, vision, and dental plans, and long-term disability and life insurance will increase to $595,803,151 in 2014, which is a $4,054,015, or 0.7 percent increase from $591,749,136 in FY 2013.

Table 4
Total Health and Other Plan Costs for the City, Employees, and Retirees in 2014 Compared to 2013

	2013	2014	Increase/ (Decrease)	Percent
City Costs Only				
Kaiser HMO	$213,512,253	$227,362,649	$13,850,396	6.5%
Blue Shield HMO	220,221,904	218,316,125	(1,905,779)	-0.9%
City Plan	48,002,758	40,740,923	(7,261,834)	-15.1%
Subtotal Health and Vision Plan	481,736,914	486,419,697	4,682,783	1.0%
Dental	31,123,486	31,959,386	835,900	2.7%
Long Term Disability and Life Insurance	4,784,845	4,784,845	0	0.0%
Total City Costs	**$517,645,245**	**$523,163,928**	**$5,518,683**	**1.1%**
Employee and Retiree Costs Only				
Kaiser HMO	$21,223,163	$23,124,625	$1,901,462	9.0%
Blue Shield HMO	37,951,651	36,603,898	(1,347,753)	-3.6%
City Plan	12,285,682	10,267,304	(2,018,378)	-16.4%
Subtotal Health and Vision Plan	71,460,496	69,995,828	(1,464,668)	-2.0%
Dental	2,582,155	2,582,155	0	0.0%
Long Term Disability and Life Insurance	61,240	61,240	0	0.0%
Total Employee and Retiree Costs	**$74,103,891**	**$72,639,223**	**($1,464,668)**	**-2.0%**
Total Costs				
Kaiser HMO	$234,735,416	$250,487,274	$15,751,859	6.7%
Blue Shield HMO	258,173,555	254,920,023	(3,253,532)	-1.3%
City Plan	60,288,439	51,008,228	(9,280,212)	-15.4%
Subtotal Health and Vision Plan	553,197,410	556,415,525	3,218,115	0.6%
Dental	33,705,642	34,541,541	835,900	2.5%
Long Term Disability and Life Insurance	4,846,084	4,846,084	0	0.0%
Total Costs	**$591,749,136**	**$595,803,151**	**$4,054,015**	**0.7%**

Of the total 2014 costs of $595,803,151 shown in Table 4 above, the City's total costs (excluding employee or retiree contributions) is $523,163,928, or approximately 87.8 percent of the total costs. Overall, the City's total cost of $523,163,928 in 2014 for the health, vision, and dental plans, and long-term disability and life insurance, is $5,518,683, or 1.1 percent more than the costs for these plans in 2013 of $517,645,245.

RECOMMENDATIONS

- Approve the proposed ordinance (File 13-0653) to amend Administrative Code Section 16.703, establishing the Health Service System's 2014 health, vision, and dental plans and premiums.
- Approve the proposed resolution (File 13-0654), setting the City's 2014 contribution to the Health Service System Trust Fund, under the Charter, of $559.65 per member per month.

Items 6 and 7 Files 13-0653 and 13-0654	Department Health Service System (HSS)

EXECUTIVE SUMMARY

Legislative Objectives

- The proposed ordinance (File 13-0653) would amend Administrative Code Section 16.703, establishing the Health Service System's 2014 health, vision, and dental plans and premiums.
- The proposed resolution (File 13-0654) would approve the 2014 employers' contribution of $559.65 per member per month to the Health Service System Trust Fund.

Fiscal Impacts

- In accordance with the City's Charter, the Health Service Board is required to conduct a survey of the ten most populous California counties each year to determine the average of the health premium contributions made by the ten counties. Based on this survey, the average 2014 contribution is $559.65 per member per month, which is $24.87 or 4.65 percent more than the ten-county average contribution of $534.78 in 2013.
- However, the City's monthly health premium contributions for employees is proposed to be (a) $1,046.99 for the City's Health Plan, a 16.84% reduction, (b) $562.30 for Kaiser, a 4.71% increase, and (c) $612.56 for Blue Shield, a 5.3% reduction.
- The total costs for the City, employees, retirees, and their dependents of $595,803,151 in 2014 for health, vision, dental, long-term disability and life insurance, is $4,054,015, or 0.7 percent more than the $591,749,136 costs for these plans in 2013.
- Of the total 2014 costs of $595,803,151, the City's costs (excluding employee or retiree contributions) are $523,163,928, or approximately 87.8 percent of the total costs.
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The Health Service Board adopts the annual health, vision, and dental plans, and the respective plan premiums and premium equivalents paid by employers and members.

- HSS employers include the City and County of San Francisco (City), the San Francisco Unified School District (SFUSD), the San Francisco Community College District (SFCCD), and the San Francisco Superior Court (Superior Court).
- HSS members are active and retired employees of the above noted employers, their dependents, and members of eligible boards and commissions. Dependents include children, spouses, domestic partners, surviving spouses of deceased members, and other legal dependents.

Under City Charter Section A8.423, the Health Service Board is required to (a) conduct a survey of the ten most populous California counties each year, excluding San Francisco, and (b) determine and set the health plan premiums paid by the City, employees, and retirees. In accordance with Section A8.423 of the City's Charter, the City's contribution to the Health Service System Trust Fund is based on the average of the contributions made by each of the ten counties.

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(1) The premiums covered by the employer for each health plan will vary according to union membership of the covered employee as per negotiated Memorandum of Understanding (MOU) agreements (please see section entitled, 'Changes in Contribution Strategy', below).

(2) Federal healthcare reform will add fees and taxes to the premium calculation (please see section entitled, 'Impacts of Federal Legislation', below).

According to Mr. Gregg Sass, Interim CFO at HSS, all other changes in premiums are a result of health plan premium increases and/or savings from under-utilization.

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[3] According to Mr. Sass, this negotiated change would impact approximately 7,800 employee-only members, which is approximately 70% of active employee-only members, by July 1, 2014. The Health Service Board approved two sets of rates to reflect this change in 2014. One set of rates is for members under this new '90/10 Contribution Model', and the other set of rates is for members under the existing contribution model.

the employee contribution amount will increase to a maximum of 10 percent of the premium. This contribution calculation is called the '90/10 Contribution Model'.

Under the '90/10 Contribution Model', the City will contribute the greater of the 10-County average amount ($559.65) or 90 percent of the employee-only premium for active employees in the Kaiser and Blue Shield populations. For active employee-only members in the City Plan, the City will contribute 90 percent of the Blue Shield employee-only premium plus one-half of the difference between 90 percent of the Blue Shield employee-only premium and 100 percent of the City Plan employee-only premium. This change applies only to those employees that do not have dependent coverage.

The City Charter states, in Section A8.423, "the average contribution made with respect to each employee by said 10 counties toward the health care plans provided for their employees ... **shall be 'the average contribution'**." According to Mr. Jon Givner, Deputy City Attorney, the Charter provides the amount that must be contributed to the Health Service System Trust Fund by the City, but that amount is not a ceiling and the City could agree to pay additional amounts to fund employee health care under an MOU with a union representing City employees.

HSS Subsidy Option

On June 14th, 2013, the Health Service Board approved another set of rates for any union that approves an MOU agreement with the City by July 31, 2013 for a different (flat premium) employee contribution amount for 2015. This flat premium would reflect a trust-funded subsidy for the employee-only employee contribution amount under the '90/10 Contribution Model'. The subsidy would smooth member transition to the 2015 contribution model. Unlike the '90/10 Contribution Model', which applies to employee-only members in Blue Shield and the City Plan only, the flat premium would apply to all members of all three plans, including Kaiser. Participation would be broader but the required contribution by individual members would be lower than under the '90/10 Contribution Model'. The San Francisco Department of Human Resources is currently involved in MOU negotiations to define the specific rates for this subsidy option.

City's Monthly Premium Costs

As previously noted, the 10-County average determined that the City contribution to the Health Service System Trust Fund in 2014 would be $559.65 per month. However, Table 1 below shows a "blended" rate for each of the three health plans for 2014 which is a weighted calculation of the City's contribution payment for active employees based on the proportion of employees subject to the '90/10 Contribution Model' versus the proportion of employees subject to the original rate schedule.

Table 1
Total Monthly Employer Rate for Active Employees in 2014

	2013	2014 Proposed	Increase	Percent Change
City Health Plan	$1,258.97	$1,046.99	($211.98)	(16.84%)
Kaiser	$537.02	$562.30	$25.28	4.71%
Blue Shield	$647.16	$612.56	($34.60)	(5.35%)

Proposed Health Plan Premiums

City Health Plan Premiums

The City Health Plan is self-funded. Amounts to cover premiums are deposited into the Health Service System Trust Fund and used to pay claims. Monthly premium amounts are based on claims experience for each type of plan member: active employees, retirees with Medicare, and retirees without Medicare.

The blended monthly employer rate, or amount that the City will pay, for single employees will decrease by 16.84 percent in 2014, as shown above in Table 1. This decrease is because of utilization savings in prior years, which appears as a rate reduction in 2014.

Under the City Health Plan, employee premiums will decrease in 2014 by approximately 2.7 percent overall, mainly because of prior-year utilization savings and the '90/10 Contribution Model'.

Kaiser Premiums

The Kaiser Plan blended monthly employer rate for single employees will increase in 2014 by 4.71 percent, as shown in Table 1 above. Under the Kaiser plan, employee premiums will increase in 2014 by approximately 5.2 percent overall. These premium increases reflect new federal healthcare reform as well as administrative cost increases at Kaiser.

Blue Shield Premiums

The Blue Shield Plan blended monthly employer rate for single employees will decrease by 5.35 percent in 2014, as shown in Table 1 above. This is because of the '90/10 Contribution Model' and slightly lower average utilization than expected. Under the Blue Shield plan, employee premiums will stay flat in 2014 except for retiree premiums, which will increase by approximately 6 percent because of federal healthcare reform and health cost increases.

Proposed Dental Plans

The Health Service System offers three dental plans, including one PPO, Delta Dental PPO, and two HMOs: Delta Care USA and Pacific Union Dental. There are no plan changes in the dental plans.

The City does not contribute to the monthly dental premium for retired employees. The City contributes the full monthly premium for active employees for the two HMOs and also

contributes part of the monthly premium for active employees for Delta Dental PPO. As shown in Table 2 below, the City's contribution to premiums will increase up to 4.2% in 2014 for all dental plans except for Pacific Union Dental, whose premiums remain unchanged from 2013.

Table 2
Total Monthly Dental Premiums

	2014	2013	Increase/ Decrease	Percent
Delta Care USA HMO				
Single Employee	$26.95	$26.00	$0.95	3.7%
Employee + One Dependent	$44.46	$42.90	$1.56	3.6%
Employee + Two or More Dependents	$65.76	$63.45	$2.31	3.6%
Pacific Union Dental HMO				
Single Employee	$27.80	$27.80	$0.00	0.0%
Employee + One Dependent	$45.90	$45.90	$0.00	0.0%
Employee + Two or More Dependents	$67.86	$67.86	$0.00	0.0%
Delta Dental PPO				
Single Employee (Total Premium)	$65.95	$63.47	$2.48	3.9%
Less Employee Contribution	($5.00)	($5.00)	$0.00	0.0%
City's Contribution	$60.95	$58.47	$2.48	4.2%
Employee + One Dependent (Total Premium)	$138.49	$133.29	$5.20	3.9%
Less Employee Contribution	($10.00)	($10.00)	$0.00	0.0%
City's Contribution	$128.49	$123.29	$5.20	4.2%
Employee + Two or More Dependents (Total Premium)	$197.84	$190.42	$7.42	3.9%
Less Employee Contribution	($15.00)	($15.00)	$0.00	0.0%
City's Contribution	$182.84	$175.42	$7.42	4.2%

Contingency and Stabilization Amounts

The HSS sets aside a portion of the Trust Fund balance[4] to provide contingencies for the self-funded dental plan, Delta Dental PPO, and to stabilize employees' dental plan premium increases. The member contributions for Delta Dental PPO plan for retirees, Delta Care USA dental plans for employees and retirees, and Pacific Union Dental plans for employees and retirees remain unchanged from the prior plan year. Pursuant to the Health Service's Self-Funded Plans' Funding Policy, no claims stabilization amount has been applied this year.

Life and Long Term Disability Insurance

The Health Service System will continue its contract with Aetna Life Insurance Company in 2014. In January 2013, Aetna Life Insurance Company was selected through a Request for Proposal (RFP) process to provide life and long term disability insurance to City employees eligible for coverage through their MOUs between the City and the respective unions.

[4] The Employee Benefit Trust Fund is funded via payroll deductions and employer contributions. Those amounts are paid into the Trust Fund and premiums are paid by the Trust Fund. The fund balance is what remains after accruing all liabilities for unpaid premiums and incurred but not reported expenses of self-insurance programs. As of June 30, 2012, the fund balance in the Trust Fund was $53.2M, which is projected to increase to $69.5M by June 30, 2013.

Impacts of Federal Legislation

As of January 1, 2014, a provision of the Federal Patient Protection and Affordable Care Act (PPACA) will take effect, introducing the Federal PPACA Legislative Fees. Implementation of another provision previously scheduled to take effect in 2014, the Federal PPACA Full Time Employee requirements, has been deferred by the federal government until 2015. Both of these provisions are briefly summarized below. Implementation of an additional provision, Federal PPACA Automatic Enrollment, has also been deferred because the Department of Labor stated that it will not issue final guidance on Automatic Enrollment until 2014. In addition to Federal PPACA requirements, the 2009 American Recovery and Reinvestment Act established a temporary Early Retiree Reinsurance Program (ERRP), also summarized below.

Federal PPACA Full Time Employee requirements

A current assessment by HSS indicates that no additional payments will be incurred under this federal legislation because both the City and the Superior Courts offer coverage to all full time employees. HSS is still working with the San Francisco Community College District (SFCCD) and the San Francisco Unified School District (SFUSD) and to assess their compliance with federal PPACA requirements. On July 2, 2013 this PPACA requirement was deferred until 2015.

Federal PPACA Legislative Fees

As a result of the federal PPACA, there are two direct fees and one tax that have been factored into the calculation of medical premium rates and premium equivalents for the 2014 plan year. The three fees are the Health Insurer Tax (HIT), Patient Centered Outcomes Research Institute (PCORI) fee, and the Transitional Reinsurance fee. Table 3 (below) summarizes the estimated cost of each of these legislative fees for 2014 for the City and County of San Francisco.[5]

Table 3
Federal PPACA Legislative Fees and Taxes ($ Millions) in 2014

	HIT	PCORI	Transitional Reinsurance	**Total**
City Plan (UHC)	$0.00	$0.01	$0.13	**$0.14**
Kaiser	$2.15	$0.09	$2.10	**$4.33**
Blue Shield	$6.27	$0.07	$1.91	**$8.26**
Delta	$0.00	N/A	N/A	**$0.00**
VSP	$0.07	N/A	N/A	**$0.07**
Total	**$8.49**	**$0.18**	**$4.13**	**$12.80**

[5] The HSS Trust Fund serves four employers: The City and County of San Francisco, the Superior Courts, San Francisco Community College District and the San Francisco Unified School District (CCSF, CRT, SFCCD, and SFUSD). The costs shown in Table 3 reflect only those PPACA charges incurred by CCSF.

Early Retiree Reinsurance Program Reimbursements

The 2009 American Recovery and Reinvestment Act established the temporary Early Retiree Reinsurance Program (ERRP) as an incentive for employers to continue early retiree health insurance coverage. This program provided federal reimbursement to eligible sponsors of employment-based plans for a portion of the costs of providing health coverage to early retirees, during the period beginning on the date the program was established, and ending on December 31, 2013. The total ERRP amount received by HSS from the federal government with interest is $3,812,749. A plan sponsor may use these ERRP reimbursements to reduce the sponsor's health benefit premiums or costs, to reduce costs for plan participants, or to reduce any combination of these costs.

However, ERRP regulations stipulate a Maintenance of Contribution (MOC), requiring that the City continue to provide at least the same level of contribution to support each plan if any of the reimbursement funds are used to offset City costs, rather than exclusively used to offset employee contributions.

On January 10, 2013, the Health Service Board approved spending the ERRP reimbursement funds exclusively to reduce participant premium contributions in order to decrease both participant and employer premiums through stabilizing membership and premium rates, which will allow HSS to bypass the MOC calculation requirements. The Health Service Board also approved apportioning the ERRP reimbursement funds based on the amount of premiums paid into each plan in proportion to each set of rates paid in 2013.

FISCAL ANALYSIS

The City's cost for health and other plans is funded by charges to each City Department for the cost of employee benefits.

As shown in Table 4 below, the total City, employee, and retiree costs for the health, vision, and dental plans, and long-term disability and life insurance will increase to $595,803,151 in 2014, which is a $4,054,015, or 0.7 percent increase from $591,749,136 in FY 2013.

Table 4
Total Health and Other Plan Costs for the City, Employees, and Retirees in 2014 Compared to 2013

	2013	2014	Increase/ (Decrease)	Percent
City Costs Only				
Kaiser HMO	$213,512,253	$227,362,649	$13,850,396	6.5%
Blue Shield HMO	220,221,904	218,316,125	(1,905,779)	-0.9%
City Plan	48,002,758	40,740,923	(7,261,834)	-15.1%
Subtotal Health and Vision Plan	481,736,914	486,419,697	4,682,783	1.0%
Dental	31,123,486	31,959,386	835,900	2.7%
Long Term Disability and Life Insurance	4,784,845	4,784,845	0	0.0%
Total City Costs	**$517,645,245**	**$523,163,928**	**$5,518,683**	**1.1%**
Employee and Retiree Costs Only				
Kaiser HMO	$21,223,163	$23,124,625	$1,901,462	9.0%
Blue Shield HMO	37,951,651	36,603,898	(1,347,753)	-3.6%
City Plan	12,285,682	10,267,304	(2,018,378)	-16.4%
Subtotal Health and Vision Plan	71,460,496	69,995,828	(1,464,668)	-2.0%
Dental	2,582,155	2,582,155	0	0.0%
Long Term Disability and Life Insurance	61,240	61,240	0	0.0%
Total Employee and Retiree Costs	**$74,103,891**	**$72,639,223**	**($1,464,668)**	**-2.0%**
Total Costs				
Kaiser HMO	$234,735,416	$250,487,274	$15,751,859	6.7%
Blue Shield HMO	258,173,555	254,920,023	(3,253,532)	-1.3%
City Plan	60,288,439	51,008,228	(9,280,212)	-15.4%
Subtotal Health and Vision Plan	553,197,410	556,415,525	3,218,115	0.6%
Dental	33,705,642	34,541,541	835,900	2.5%
Long Term Disability and Life Insurance	4,846,084	4,846,084	0	0.0%
Total Costs	**$591,749,136**	**$595,803,151**	**$4,054,015**	**0.7%**

Of the total 2014 costs of $595,803,151 shown in Table 4 above, the City's total costs (excluding employee or retiree contributions) is $523,163,928, or approximately 87.8 percent of the total costs. Overall, the City's total cost of $523,163,928 in 2014 for the health, vision, and dental plans, and long-term disability and life insurance, is $5,518,683, or 1.1 percent more than the costs for these plans in 2013 of $517,645,245.

RECOMMENDATIONS

- Approve the proposed ordinance (File 13-0653) to amend Administrative Code Section 16.703, establishing the Health Service System's 2014 health, vision, and dental plans and premiums.
- Approve the proposed resolution (File 13-0654), setting the City's 2014 contribution to the Health Service System Trust Fund, under the Charter, of $559.65 per member per month.

Health Service System
CITY & COUNTY OF SAN FRANCISCO

MYHSS.ORG

Memorandum

DATE: June 18, 2013

TO: Supervisor Mark Farrell
Board of Supervisors

FROM: Lisa Ghotbi
Acting Director, Health Service System

RE: Annual Rates and Benefits Ordinance for Plan Year beginning January 1, 2014 and ending December 31, 2014 – Amendment of Section 16.703 of the San Francisco Administrative Code

Attached are the following documents relating to the above matter:

1. Proposed ordinance (approved as to form by the City Attorney's Office) amending Section 16.703 of the San Francisco Administrative Code, approving the Plans and Contribution Rates for the Plan Year beginning January 1, 2014 and ending December 31, 2014, adopted by the Health Service Board on June 13, 2013;
2. Actuarial Report dated June 18, 2013 from Aon Hewitt Health and Benefits, as required under Section A8.422 of Appendix A to the San Francisco Charter, including summaries of rates and benefits as adopted by the Health Service Board on June 13, 2013.
3. Membership Master Report dated June 3, 2013 reflecting total enrollment distribution across the three different medical plans, the different dental plans and life and long-term disability; and
4. Form SFEC-126 (Notification of Contract Approval) for the following vendors: Kaiser Foundation Health Plan (Northern and Southern California Regions), Blue Shield of California, United HeathCare Services, Inc. (City Plan), Delta Dental of California, Pacific Union Dental (a subsidiary of United HealthGroup), Vision Service Plan and Aetna Life Insurance Company.

We are happy to provide you with any additional reports or materials you may need in connection with the enclosed ordinance.

Attach.

cc: Members, Health Service Board (w/electronic attach.) (via e-mail)
Erik Rapoport (w/electronic attach.)
Ben Rosenfield (w/electronic attach.)
Anil Kochhar (w/electronic attach.)
Gregg Sass (w/electronic attach.)

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AON Hewitt

June 18, 2013

Board of Supervisors
City and County of San Francisco
City Hall, Room 244
1 Dr. Carlton B. Goodlett Place
San Francisco, CA 94102

RE: January 1, 2014 to December 31, 2014 Plan Benefits, Rates and Contribution

Honorable Members of the Board of Supervisors:

This letter serves to document our position as the consultant and actuary to the Health Service System (HSS) in regards to the completed rate and contribution setting process for the plan year from January 1, 2014 to December 31, 2014. This process was concluded on June 13, 2013 under the direction of the Rates and Benefits Committee (the Committee) of the Health Service Board (the HSB). The rates, benefits, and contributions presented herein were approved by the full HSB during their meeting on June 13, 2013. This report will reference attached Exhibits, as well as Tables embedded in this letter.

In our opinion, the process was completed in a thorough manner. In particular, it is our opinion that:

- The insured premiums and administrative fees agree with HSS vendor's final rates and represent a fair price given the services provided, and;
- The premium equivalents set for the HSS self-funded and flex-funded programs: City Plan (UHC), Active Dental plans and the Blue Shield flex funded plan represent our best estimate of future expenditures based on the information available at the time these were developed. Existing Trust Fund assets are expected to be sufficient to protect the HSS Trust Fund against adverse claims experience.

Legislative Update

The Federal Patient Protection and Affordable Care Act (PPACA)

In 2014, many provisions of the federal Patient Protection and Affordable Care Act (PPACA) will take effect. The Health Service System is working with all four employers served by the Trust: The City and County of San Francisco, the Superior Courts, San Francisco Community College District and the San Francisco Unified School District (CCSF, CRT, CCD, and USD) to make sure all new requirements are implemented. Below you will find a brief explanation of some of the provisions that will have the greatest effect.

Federal PPACA Full Time Employee requirements

The federal PPACA defines a full-time employee as an employee who was employed on average at least 30 hours of service per week, or 130 hours of service in a calendar month. Hours of service include both time actively working, and paid time due to vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty or leave of absence. This definition will be used to

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determine any Shared Responsibility Penalties or State Exchange subsidies. Our current assessment indicates that no shared responsibility payments will be incurred because both CCSF and CRT offer coverage to all full time employees. HSS is still working with CCD and USD to assess compliance with this requirement.

Federal PPACA Automatic Enrollment (deferred)

The federal PPACA requires that employers automatically enroll new full-time employees in one of the employer's health benefits plans (subject to any waiting period authorized by law). Further it is required that employees be given adequate notice and the opportunity to opt out of any coverage in which they were automatically enrolled. The Department of Labor stated that it will not issue final guidance on Automatic Enrollment until 2014. Employers do not need to comply with this requirement until these final regulations are in effect.

Early Retiree Reinsurance Program Reimbursements

The 2009 American Recovery and Reinvestment Act included a provision that established the temporary Early Retiree Reinsurance Program (ERRP) as an incentive for employers to continue early retiree coverage which provided reimbursement to eligible sponsors of employment-based plans for a portion of the costs of providing health coverage to early retirees, during the period beginning on the date on which the program is established, and ending on January 1, 2014. Any reimbursements received need to be used in full by the end of 2014. HSS received a total of $3,692,572 in reimbursements. Please note that interest has been credited from the time these reimbursements were received to the midpoint of the time period in which the money will be dispersed. The total ERRP amount with interest credited comes to $3,812,749. A plan sponsor may use ERRP reimbursements only for the following purposes:

1) To reduce the sponsor's health benefit premiums or health benefit costs,

2) To reduce health benefit premium contributions, copayments, deductibles, coinsurance, or other out-of-pocket costs, or any combination of these costs, for plan participants, or

3) To reduce any combination of the costs specified in (1) and (2)

In the ERRP regulation, it is noted that sponsors will continue to provide at least the same level of contribution to support the applicable plan, as it did before the program. (This is called Maintenance of Contribution (MOC)). A MOC calculation must be performed if the plan sponsor decides to allocate a portion of the money to their own costs rather than using all of the money exclusively for their employees. The HSS ERRP Application stated that ERRP funds would be "used to reduce both the plan participants' costs as well as the participating employer's increases in health benefit premium costs." It also stated that the Health Service Board would make the "determination of the precise approach followed to disburse the reinsurance funds." The HSB was advised that the Centers for Medicare and Medicaid Services were closely monitoring and auditing the use of ERRP funds specifically compliance with MOC calculations and the applications stated goals.

On January 10, 2013 Aon Hewitt/HSS recommended to the Health Service Board that the funds be spent exclusively to reduce participant premium contributions in order to decrease both participant

and employer premiums through stabilizing membership and premium rates. Applying the funds exclusively to employee contributions also allowed HSS to bypass the MOC calculation which saved approximately $42,750 in consulting fees to prepare. The HSB accepted this recommendation to use ERRP funds to lower employee contributions. The Health Service Board voted to apportion the ERRP monies based on the amount of premiums paid into each plan by coverage tier. The monthly employee contribution subsidy, including credited interest, for each plan and tier can be found in the following Table 1:

Table 1: ERRP Employee Contribution Subsidy by Coverage Tier

	Actives			Non-Medicare			Medicare		
	EE	EE+1	EE+2	EE	EE+1	EE+2	EE	EE+1	EE+2
CityPlan	$1.99	$1.93	$1.44	$2.44	$2.45	$0.38	$0.00	$2.26	$0.27
BlueShield	$4.57	$7.50	$29.02	$1.29	$3.24	$2.65	$0.00	$2.56	$0.64
Kaiser	$1.50	$0.86	$15.66	$0.15	$2.32	$1.30	$0.00	$4.49	$0.82

Federal PPACA Legislative Fees

As a result of the federal PPACA, there are two direct fees and one Health Insurance Tax that have been factored into the calculation of medical premium rates and premium equivalents for the 2014 plan year. This section of the law brings increased scrutiny and accompanying fines by three different federal agencies; Department of Labor (DOL), Health and Human Services (HHS), and Internal Revenue Service (IRS). Please find below a brief explanation of these fees:

- Health Insurer Tax (HIT): This tax will impact all fully insured or flex funded plans that HSS offers. This obligation on insurers is divided among insurers according to a formula based on each insurer's net premiums. Aon Hewitt estimates that this tax will result in an extra $10.91M in premiums or an increase of 1.5% in premiums paid to insurers for all HSS fully insured or flex-funded plans in 2014.

- Patient Centered Outcomes Research Institute (PCORI) fee: A $2.00 charge per enrollee per year will be assessed to all participants (actives, retirees without Medicare, and retirees with Medicare) in medical-only health plans in 2013. This fee is expected to increase to approximately $2.10 per enrollee per year in 2014. Aon Hewitt estimates that this tax will result in an extra $0.24M in 2014 premiums or a 0.03% increase. This fee is expected to increase with inflation until 2019 when the fee will stop being assessed. This fee will be collected by the Internal Revenue Service.

- Transitional Reinsurance fee: A $63.00 charge per enrollee per year will be assessed to all participants where Medicare is not the primary payer in 2014. Aon Hewitt estimates that this tax will result in an extra $5.49M in 2014 premiums or a 0.76% increase. This fee is expected to decrease in 2015 and 2016. 2016 is the last year in which this fee will be assessed. This fee was proposed by the Department of Health and Human Services.

The following table summarizes the estimated aggregate cost of each of these legislative fees for 2014:

Table 2a 2014 Legislative Fees ($ millions) All Employers						
Fee	City Plan (UHC)	Kaiser	Blue Shield	Delta	VSP	Total
HIT	$0.00	$2.92	$7.90	$0.00	$0.09	$10.91
PCORI	$0.02	$0.13	$0.09	N/A	N/A	$0.24
Transitional Reinsurance	$0.28	$2.85	$2.36	N/A	N/A	$5.49
Total	**$0.30**	**$5.90**	**$10.35**	**$0.00**	**$0.09**	**$16.65**

Table 2b 2014 Legislative Fees ($ millions) CCSF Only						
Fee	City Plan (UHC)	Kaiser	Blue Shield	Delta	VSP	Total
HIT	$0.00	$2.15	$6.27	$0.00	$0.07	$8.49
PCORI	$0.01	$0.09	$0.07	N/A	N/A	$0.18
Transitional Reinsurance	$0.13	$2.10	$1.91	N/A	N/A	$4.13
Total	**$0.14**	**$4.33**	**$8.26**	**$0.00**	**$0.07**	**$12.80**

City Contributions under the 10-County Survey

According to the City Charter, the City's contribution towards medical benefits is determined by the results of a survey of the amount of premium contributions provided by the ten most populous counties in California, excluding San Francisco. For the 2013 plan year, the survey determined that the average monthly contribution increased 4.65% from $534.78 to $559.65. Exhibit 1 presents the individual county responses from this survey.

Year over Year Health Plan Cost Comparison

Annual costs for Medical Plans are shown in millions:

TABLE 3 January 1, 2014 to December 31, 2014 Aggregate Medical Cost ($ millions)			
	Member Contributions	Employer Contributions	Aggregate Plan Cost
Current Rates	$79.0	$598.3	$677.3
Final Renewal Rates (including plan design changes)	$80.9	$612.4	$693.3
$ Difference	$1.9	$14.1	$16.0
% Difference	2.41%	2.36%	2.36%

The above table illustrates an increase in aggregate plan costs of $16.0 million, or 2.36%, for only the three medical health plans (includes vision and HSS Communications and Healthcare Sustainability expense) for the January 1, 2014 to December 31, 2014 plan year. This increase in costs will be split 12.0%/88.0% between the members and employers with member contributions

increasing $1.9 million and employer contributions increasing $14.1 million. Depending on how the HSS Trust Subsidy is adopted, member contributions could be lowered by as much as $3.4 million.

Change in City and County (CCSF) Contribution Strategy

As of 2014, a negotiated change will affect certain groups within the CCSF population. Historically, active CCSF employees have paid nothing for employee-only (EE only) coverage. Starting January 1, 2014 for some union MOU agreements, the employee contribution amount will increase to a maximum of 10% of the premium. This negotiated change will impact approximately 70% of active EE-only employees in 2014. The contribution calculation, called the '90/10 Contribution Model', follows this algorithm:

> For active EE only's in the Kaiser and Blue Shield populations, the City will contribute the greater of the 10-County amount ($559.65) or 90% of the employee-only premium. For active EE only's in the City Plan population, the City will contribute 90% of the Blue Shield employee-only premium and half of the difference between 90% of the Blue Shield employee-only premium and 100% of the City Plan employee-only premium.

This change applies only to those employees in the EE only category. Those in the EE+1 (employee plus one dependent) and EE+2 (employee plus two or more dependents) categories will continue to contribute to their dependent coverage consistent with prior union MOU agreements.

Aon Hewitt produced two rate cards, approved by the HSB, for 2014. One rate card for members under this new '90/10 Contribution Model', and one rate card for the members under the existing contribution model.

HSS Subsidy Option

Aon Hewitt produced an additional rate card for 2014, approved by the HSB on June 14th, 2013, with a trust-funded subsidy for the EE only employee contribution amount under the '90/10 Contribution Model'. This rate card would be applied to any union that completes an agreement with the City for a different (flat premium) 2015 employee contribution amount by July 31, 2013. This subsidy would smooth member transition to the 2015 contribution model avoiding member disruption and continuity of care issues. Additionally, Exhibits 12 and 13 show the impact of the trust subsidy.

Rates, Contributions, and Benefits for HMOs

Consistent with the 2013 plan year, two HMOs will be offered to HSS members for the 2014 plan year; Kaiser and Blue Shield of California.

Plan Design Changes for HMOs

As part of the annual Rates and Benefits process HSS, Aon Hewitt, the Rates and Benefits Committee of the HSB, and the HSB reviewed the continued appropriateness and competitiveness of the plan designs for the HMOs. The benchmark information (available on www.myhss.org website – May 9, 2013 for Blue Shield and June 13, 2013 for Kaiser) compiled indicates all member point of service plan design elements were competitive with the offerings of similar employers. No plan design changes were recommended to the Rates and Benefits Committee and the HSB.

Kaiser

The HSB was presented with the benchmarking of the current plan design which was shown to be in line with the comparators. The HSB adopted no plan design changes for the Kaiser plan.

The final negotiated rate change for Kaiser is an overall increase of 5.25% for actives and retirees without Medicare. For retirees with Medicare the rate change is 5.1%. This rate is subject to finalization and reconciliation in the 2015 plan year. This results in an overall estimated increase of $16.0M annually.

The aggregate cost for Kaiser for the 2014 plan year is projected at $322.8 million, with $27.2 million in member contributions and $295.6 million in employer contributions. Table 4, on page 9 provides an overview of annualized costs.

Blue Shield of California

The HSB was presented with the benchmarking of the current plan design which was shown to be in line with the comparators. They adopted no plan design changes for the Blue Shield plan.

On January 1, 2013, the funding arrangement for actives and retirees without Medicare switched from fully-insured to flex-funded. Aon Hewitt develops the premium equivalents for the flex-funded plan. Aon Hewitt worked with HSS, HSS' ACO partners, and Blue Shield to maintain a flat renewal for the flex-funded portion of the Blue Shield plan. Including all applicable legislative fees, the final rate change for actives and retirees without Medicare is 0.00% (no change from the 2013 benefit period). Retirees with Medicare remain in the fully-insured plan with a final rate increase of 5.9%. This results in an overall estimated increase of $1.7M annually.

The aggregate cost for the Blue Shield HMO for the 2014 plan year is projected at $308.5 million, with $41.9 million in member contributions and $266.5 million in employer contributions. Table 4, on page 9, provides an overview of annualized costs.

HMO Contributions

Contributions for HMO members were determined in accordance with the City Charter and include the new 10-County survey result of $559.65. Exhibits 2a-2b and 3a-3c summarize the changes in contributions for actives and retirees for the Kaiser plan and the Blue Shield of California plans respectively for the 2014 plan year.

Rates, Contributions, and Benefits for City Plan (UHC)

The City Plan (UHC) is a self-funded plan administered by United Healthcare (UHC). The medical and pharmacy monthly premium equivalent costs were developed separately for actives, retirees without Medicare and retirees with Medicare based on group-specific experience. Additionally, Aon Hewitt provided a retrospective analysis of historical rates and experience to examine the actual cost trends evident in the City Plan's (UHC) recent claims data. These analyses were considered in conjunction with overall industry and normative data when determining the premium levels for the 2014 plan year (available at www.myhss.org website – February 14, 2013 and May 9, 2013).

As part of the annual Rates and Benefits process HSS, Aon Hewitt, the Rates and Benefits Committee, and the HSB, reviewed the continued appropriateness and competitiveness of the benefit design for City Plan (UHC). The HSB found that the benefit design of the City Plan was competitive and no plan design changes were implemented.

The UHC administration fees were unchanged from the 2013 plan year. UHC waived administrative fee increases as a concession related to UHC's poor implementation of a January 2013 pharmacy benefit which caused significant member disruption.

The final full monthly premium equivalents with no plan design changes result in an overall decrease of 2.67%. For actives, retirees without Medicare, and retirees with Medicare it is a decrease of 2.48%, 2.55%, and 2.77%, respectively. These premium equivalents are decreasing due to the underwriting gains caused by lower utilization that the City Plan produced during Calendar Year 2012. Underwriting gains are a result of HSS initiatives to improve network management, Medicare coordination, and claim administration as well as lower utilization trends. For the end of 2012, over $7M of under writing gains were put into the City Plan Stabilization Fund. Per the HSS Stabilization Fund Policy, one-third of the amount in the Stabilization Fund ($2.365M) was spread across all rating tiers to lower the City Plan premium equivalents by the aforementioned percentages. Since the pharmacy portion of the Medicare rate is covered by a fully insured EGWP product, there should have been an increase in the premiums due to the Health Insurer Tax. However, since there was no increase to the EGWP premium for 2014, no additional Health Insurer Tax costs will be incurred.

Exhibit 4 summarizes the change in full monthly premium equivalents for the City Plan (UHC). Included in the premium equivalent rate, pursuant to the HSB's Self Funded Plans' Funding Policy, is the application of the claims stabilization amount.

The aggregate cost for the City Plan (UHC) for the 2014 plan year is projected at $62.1 million, with $11.8 million in member contributions and $50.3 million in employer contributions. This results in an overall estimated decrease of $1.7M annually. Table 4, on page 9, provides an overview of annualized costs.

Exhibits 5a-5c summarize the changes in employee and retiree contributions for City Plan (UHC). These contributions were determined in accordance with the City Charter, and include the new 10-County Survey result of $559.65. The above exhibit does not include any City contributions that may be negotiated in MOUs.

Rates and Benefits for the Vision Plan

Members enrolled in any medical plan offered by HSS also receive vision benefits through Vision Service Plan (VSP). The cost of the vision benefit is a component of the cost of the medical plan and has been included in the rate exhibits referenced above.

The vision plan is a fully-insured plan. As of January 1, 2014, VSP vision plan rates will increase 5.5%. The aggregate cost for the VSP vision plan for the 2014 plan year is projected at $4.7 million. This results in an overall estimated increase of $0.2M annually. Approximately 2% of this increase is due to the Health Insurer Tax applied to full insured plans. Without the 2% increase from the Health

Insurer Tax, this renewal is only 3.5%. Exhibit 6 in the attachment summarizes the VSP vision plan costs.

Rates, Contributions, and Benefits for Dental Plans

Three dental plans are offered to HSS members: Delta Dental PPO, Delta Care USA and Pacific Union Dental. The Delta Dental PPO plan is a dental PPO with a network of preferred providers while the other two plans are dental HMOs with closed panels of providers. The City pays part of the cost of dental benefits for active CCSF employees while retirees pay the full cost of their dental benefits.

The Delta Dental PPO plan for active employees is self-funded and administered by Delta Dental of California. Future plan costs are projected based on the City employees' claim experience. Delta Dental's fee for claim administration remains unchanged from the 2013 plan year and was extended until December 31, 2015.

As part of the annual Rates and Benefits process HSS, Aon Hewitt, the Rates and Benefits Committee, and the HSB, reviewed the continued appropriateness and competitiveness of the benefit design for the Active Delta Dental PPO plan.

The aggregate premium for the self-funded Delta Dental PPO plan for active employees is an increase of 3.9%. This results in an increase to annual premiums of $1.7M. Since this is a self-insured plan, the Health Insurer Tax does not apply and the increase is all experience driven.

The Delta Dental PPO plan for retirees, Delta Care USA dental plans for employees and retirees, and Pacific Union Dental plans for employees and retirees are all fully-insured. The fully-insured premiums for the Delta Dental PPO plan for retirees increased 6.27%. 1.13% of this increase is due to the Health Insurer Tax applied to full insured plans. Without the 1.13% increase from the Health Insurer Tax, this renewal is only 5.14%. The fully-insured premiums for the Delta Care USA dental plans for employees and retirees increased by 3.64%. 1.1% of this increase is due to the Health Insurer Tax applied to full insured plans. Without the 1.1% increase from the Health Insurer Tax, this renewal is only 2.54%. The fully-insured premiums for the Pacific Union plans are unchanged from the 2013 plan year rates.

For the 2014 plan year the City will contribute the full premium rate towards each of the dental HMO plans for CCSF employees. For the self-funded Dental PPO the City will contribute the full monthly premium rate minus employee contributions of $5.00, $10.00, and $15.00 for employee only, employee with one dependent, and employee with two or more dependents respectively. The member contributions for Delta Dental PPO plan for retirees, Delta Care USA dental plans for employees and retirees, and Pacific Union Dental plans for employees and retirees remain unchanged from the prior plan year. Pursuant to the Health Service's Self Funded Plans' Funding Policy no claims stabilization amount has been applied this year.

Exhibit 7, 8, and 9 summarize the changes in dental cost for the active [self-funded] and retirees for the Delta Dental PPO plan, Delta Care USA plan, and Pacific Union Dental plans respectively.

The aggregate dental plan cost for the 2014 plan year is projected at $43.9 million, with $3.2 million in member contributions and $40.7 million in employer contributions. This represents an increase to annual premiums of $1.6M. Table 4, on page 9 provides an overview of annualized costs.

Life and Long Term Disability (LTD) Insurance

Life and Long Term Disability rates remain unchanged from the 2013 rates. The aggregate life and LTD plan cost for the 2014 plan year is projected at $6.1 million, with $100,000 in member contributions and $6.0 million in employer contributions. Table 4, on page 9 provides an overview of annualized costs.

Summary of Projected 2014 Plan Year Costs

Illustrated below, in Table 4, is a summary of how projected 2014 aggregate HSS plan costs are distributed across the different plans available to employees and retirees. Costs are shown only for those plans where the employers subsidize the total premium cost. The premium costs associated with the VSP vision core plan are included in the medical plan's costs.

TABLE 4 *
Distribution of Aggregate Plan Costs ($millions)

	Member Contributions	Employer Contributions	Aggregate Plan Cost	Member Contributions as a % of Aggregate Costs	Employer Contributions as a % of Aggregate Costs
Kaiser HMO	**$27.2**	**$295.6**	**$322.8**	**8.43%**	**91.57%**
$ Increase	$1.3	$14.7	$16.0		
% Increase	4.93%	5.25%	5.22%		
Blue Shield HMO	**$41.9**	**$266.5**	**$308.5**	**13.60%**	**86.40%**
$ Increase	-$0.1	$1.8	$1.7		
% Increase	-0.23%	0.67%	0.55%		
City Plan	**$11.8**	**$50.3**	**$62.1**	**18.94%**	**81.06%**
$ Increase	$0.7	-$2.4	-$1.7		
% Increase	6.76%	-4.63%	-2.66%		
Dental **	**$3.2**	**$40.7**	**$43.9**	**7.38%**	**92.62%**
$ Increase	$0.0	$1.6	$1.6		
% Increase	0.00%	2.68%	2.48%		
LTD	**$0.0**	**$5.7**	**$5.7**	**0.00%**	**100.00%**
$ Increase	$0.0	$0.0	$0.0		
% Increase	0.00%	0.00%	0.00%		
Life	**$0.1**	**$0.3**	**$0.4**	**19.55%**	**80.45%**
$ Increase	$0.0	$0.0	$0.0		
% Increase	0.00%	0.00%	0.00%		
Total	**$84.2**	**$659.1**	**$743.3**	**11.33%**	**88.67%**
$ Increase	$1.9	$15.7	$17.6		
% Increase	2.34%	2.44%	2.43%		

* Figures vary due to rounding

** Dental costs are for active employees only, retirees and surviving spouses have not been included

The overall estimated increase of 2.43% is higher than the corresponding January 1, 2013 to December 31, 2013 plan year estimated increase of 1.43%. Of this 2.43% increase, Aon Hewitt estimates that approximately 2.29% of this increase can be attributed to the new PPACA legislative taxes. This year's projected aggregate cost increase also compares very favorably with available benchmark information. This statistic is supported by the analysis titled "2013 Health Care Trend Survey" published in June 2013. Employers that were analyzed indicated Medical and Pharmacy cost increases in the range of 8% to 9%.

Conclusion

Based on extensive evaluation and collaboration with HSS, Aon Hewitt validates all of the findings presented within this report. Aon Hewitt would be pleased to answer any questions or provide clarification about the information included in this letter to any interested parties.

Sincerely,

Anil P Kochhar

Anil Kochhar, ASA, MAAA

Copy:
Members of the Health Service Board
Catherine Dodd, PhD - Health Service System
Lisa Ghotbi - Health Service System
Gabe Briggs – Aon Hewitt

San Francisco Health Service System

Board of Supervisors

10 County Survey Results and Rates and Benefits Decisions for Calendar Year 2014

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June 18, 2013

Prepared by Aon Hewitt
Health and Benefits

AON Hewitt

10-County Survey Results

Exhibit 1

Rank	County	CY 2013	CY 2014	% Change
1	Los Angeles	$515.07	$552.40	7.25%
2	San Diego	$444.86	$445.29	0.10%
3	Orange	$506.94	$544.46	7.40%
4	Riverside	$545.54	$606.39	11.15%
5	San Bernardino *	$398.98	$413.51	3.64%
6	Santa Clara *	$643.13	$656.34	2.05%
7	Alameda	$588.99	$638.47	8.40%
8	Sacramento	$696.00	$714.53	2.66%
9	Contra Costa	$553.15	$574.27	3.82%
10	Fresno	$455.17	$450.86	-0.95%
	10-County Average	**$534.78**	**$559.65**	**4.65%**

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Kaiser HMO: Final Active/Early Retiree/Medicare Monthly Contributions Calendar Year 2014

Exhibit 2a
Historic CCSF MOU Agreements

		Active			Early Retiree			MAPD/COB			
		EE	EE+1	EE+2	EE	EE+1	EE+2	EE	EE+1	EE+2 (All Medicare)	EE+2
Members	Plan Year 2013	$0.00	$2.24	$247.00	$1.12	$268.61	$712.65	$0.00	$166.70	$499.23	$610.74
	Plan Year 2014	$0.00	$4.60	$247.41	$2.58	$281.95	$750.32	$0.00	$170.74	$525.00	$641.76
	% increase	0.00%	105.36%	0.17%	130.36%	4.97%	5.29%	0.00%	2.42%	5.16%	5.08%
	$ increase	$0.00	$2.36	$0.41	$1.46	$13.34	$37.67	$0.00	$4.04	$25.77	$31.02
Employer	Plan Year 2013	$537.02	$1,069.77	$1,269.05	$1,076.98	$1,344.48	$1,344.48	$335.43	$502.13	$502.13	$502.13
	Plan Year 2014	$565.11	$1,123.59	$1,348.13	$1,132.09	$1,415.80	$1,414.78	$352.49	$532.21	$527.72	$528.54
	% increase	5.23%	5.03%	6.23%	5.12%	5.30%	5.23%	5.09%	5.99%	5.10%	5.26%
	$ increase	$28.09	$53.82	$79.08	$55.11	$71.32	$70.30	$17.06	$30.08	$25.59	$26.41
Total	Plan Year 2013	**$537.02**	**$1,072.01**	**$1,516.05**	**$1,078.10**	**$1,613.09**	**$2,057.13**	**$335.43**	**$668.83**	**$1,001.36**	**$1,112.87**
	Plan Year 2014	**$565.11**	**$1,128.19**	**$1,595.54**	**$1,134.67**	**$1,697.75**	**$2,165.10**	**$352.49**	**$702.95**	**$1,052.72**	**$1,170.30**
	% increase	5.23%	5.24%	5.24%	5.25%	5.25%	5.25%	5.09%	5.10%	5.13%	5.16%
	$ increase	$28.09	$56.18	$79.49	$56.57	$84.66	$107.97	$17.06	$34.12	$51.36	$57.43

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Historic CCSF MOU Agreements – Employer pays 100% of employee-only coverage tier

Kaiser HMO: Final Active/Early Retiree/Medicare Monthly Contributions Calendar Year 2014

Exhibit 2b
'90/10 Contribution Model' CCSF MOU Agreements

		Active			Early Retiree			MAPD/COB			
		EE	EE+1	EE+2	EE	EE+1	EE+2	EE	EE+1	EE+2 (All Medicare)	EE+2
Members	Plan Year 2013	$0.00	$2.24	$247.00	$1.12	$268.61	$712.65	$0.00	$166.70	$499.23	$610.74
	Plan Year 2014	$3.96	$4.60	$247.41	$2.58	$281.95	$750.32	$0.00	$170.74	$525.00	$641.76
	% increase	0.00%	105.36%	0.17%	130.36%	4.97%	5.29%	0.00%	2.42%	5.16%	5.08%
	$ increase	$3.96	$2.36	$0.41	$1.46	$13.34	$37.67	$0.00	$4.04	$25.77	$31.02
Employer	Plan Year 2013	$537.02	$1,069.77	$1,269.05	$1,076.98	$1,344.48	$1,344.48	$335.43	$502.13	$502.13	$502.13
	Plan Year 2014	$561.15	$1,123.59	$1,348.13	$1,132.09	$1,415.80	$1,414.78	$352.49	$532.21	$527.72	$528.54
	% increase	4.49%	5.03%	6.23%	5.12%	5.30%	5.23%	5.09%	5.99%	5.10%	5.26%
	$ increase	$24.13	$53.82	$79.08	$55.11	$71.32	$70.30	$17.06	$30.08	$25.59	$26.41
Total	Plan Year 2013	**$537.02**	**$1,072.01**	**$1,516.05**	**$1,078.10**	**$1,613.09**	**$2,057.13**	**$335.43**	**$668.83**	**$1,001.36**	**$1,112.87**
	Plan Year 2014	**$565.11**	**$1,128.19**	**$1,595.54**	**$1,134.67**	**$1,697.75**	**$2,165.10**	**$352.49**	**$702.95**	**$1,052.72**	**$1,170.30**
	% increase	5.23%	5.24%	5.24%	5.25%	5.25%	5.25%	5.09%	5.10%	5.13%	5.16%
	$ increase	$28.09	$56.18	$79.49	$56.57	$84.66	$107.97	$17.06	$34.12	$51.36	$57.43

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'90/10 Contribution Model' CCSF MOU Agreements – Employer pays 90% of employee-only coverage tier

Blue Shield HMO: Final Active/Early Retiree/Medicare Monthly Contributions Calendar Year 2014

Exhibit 3a
Historic CCSF MOU Agreements

		Active (Bargained)			Early Retiree			MAPD/COB			
		EE	EE+1	EE+2	EE	EE+1	EE+2	EE	EE+1	EE+2 (All Medicare)	EE+2
Members	Plan Year 2013	$0.00	$85.52	$520.71	$26.24	$335.39	$859.70	$0.00	$180.64	$541.25	$716.09
	Plan Year 2014	$0.00	$80.22	$466.87	$42.57	$363.30	$899.52	$0.00	$188.72	$573.16	$726.27
	% increase	0.00%	-6.20%	-10.34%	62.25%	8.32%	4.63%	0.00%	4.47%	5.90%	1.42%
	$ increase	$0.00	($5.30)	($53.84)	$16.33	$27.91	$39.82	$0.00	$8.08	$31.91	$10.18
Employer	Plan Year 2013	$647.16	$1,206.79	$1,307.06	$1,409.74	$1,745.75	$1,756.90	$363.30	$543.93	$543.93	$543.93
	Plan Year 2014	$647.37	$1,212.51	$1,361.49	$1,393.62	$1,718.26	$1,717.67	$384.60	$578.45	$575.89	$576.53
	% increase	0.03%	0.47%	4.16%	-1.14%	-1.57%	-2.23%	5.86%	6.35%	5.88%	5.99%
	$ increase	$0.21	$5.71	$54.43	($16.13)	($27.49)	($39.23)	$21.30	$34.53	$31.96	$32.60
Total	Plan Year 2013	**$647.16**	**$1,292.31**	**$1,827.77**	**$1,435.98**	**$2,081.14**	**$2,616.60**	**$363.30**	**$724.57**	**$1,085.18**	**$1,260.02**
	Plan Year 2014	**$647.37**	**$1,292.73**	**$1,828.36**	**$1,436.19**	**$2,081.56**	**$2,617.19**	**$384.60**	**$767.17**	**$1,149.05**	**$1,302.80**
	% increase	0.03%	0.03%	0.03%	0.01%	0.02%	0.02%	5.86%	5.88%	5.89%	3.40%
	$ increase	$0.21	$0.42	$0.59	$0.21	$0.42	$0.59	$21.30	$42.61	$63.87	$42.78

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Historic CCSF MOU Agreements – Employer pays 100% of employee-only coverage tier

Blue Shield HMO: Final Active/Early Retiree/Medicare Monthly Contributions Calendar Year 2014

Exhibit 3b
'90/10 Contribution Model' CCSF MOU Agreements

		Active (Bargained)			Early Retiree			MAPD/COB			
		EE	EE+1	EE+2	EE	EE+1	EE+2	EE	EE+1	EE+2 (All Medicare)	EE+2
Members	Plan Year 2013	$0.00	$85.52	$520.71	$26.24	$335.39	$859.70	$0.00	$180.64	$541.25	$716.09
	Plan Year 2014	$60.17	$80.22	$466.87	$42.57	$363.30	$899.52	$0.00	$188.72	$573.16	$726.27
	% increase	0.00%	-6.20%	-10.34%	62.25%	8.32%	4.63%	0.00%	4.47%	5.90%	1.42%
	$ increase	$60.17	($5.30)	($53.84)	$16.33	$27.91	$39.82	$0.00	$8.08	$31.91	$10.18
Employer	Plan Year 2013	$647.16	$1,206.79	$1,307.06	$1,409.74	$1,745.75	$1,756.90	$363.30	$543.93	$543.93	$543.93
	Plan Year 2014	$587.20	$1,212.51	$1,361.49	$1,393.62	$1,718.26	$1,717.67	$384.60	$578.45	$575.89	$576.53
	% increase	-9.26%	0.47%	4.16%	-1.14%	-1.57%	-2.23%	5.86%	6.35%	5.88%	5.99%
	$ increase	($59.96)	$5.71	$54.43	($16.13)	($27.49)	($39.23)	$21.30	$34.53	$31.96	$32.60
Total	Plan Year 2013	**$647.16**	**$1,292.31**	**$1,827.77**	**$1,435.98**	**$2,081.14**	**$2,616.60**	**$363.30**	**$724.57**	**$1,085.18**	**$1,260.02**
	Plan Year 2014	**$647.37**	**$1,292.73**	**$1,828.36**	**$1,436.19**	**$2,081.56**	**$2,617.19**	**$384.60**	**$767.17**	**$1,149.05**	**$1,302.80**
	% increase	0.03%	0.03%	0.03%	0.01%	0.02%	0.02%	5.86%	5.88%	5.89%	3.40%
	$ increase	$0.21	$0.42	$0.59	$0.21	$0.42	$0.59	$21.30	$42.61	$63.87	$42.78

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'90/10 Contribution Model' CCSF MOU Agreements – Employer pays 90% of employee-only coverage tier

Blue Shield HMO: Final Active/Early Retiree/Medicare Monthly Contributions Calendar Year 2014

Exhibit 3c
HSS Trust Subsidy of the '90/10 Contribution Model'

		Active (Bargained)			Early Retiree			MAPD/COB			
		EE	EE+1	EE+2	EE	EE+1	EE+2	EE	EE+1	EE+2 (All Medicare)	EE+2
Members	Plan Year 2013	$0.00	$85.52	$520.71	$26.24	$335.39	$859.70	$0.00	$180.64	$541.25	$716.09
	Plan Year 2014	$3.96	$80.22	$466.87	$42.57	$363.30	$899.52	$0.00	$188.72	$573.16	$726.27
	% increase	0.00%	-6.20%	-10.34%	62.25%	8.32%	4.63%	0.00%	4.47%	5.90%	1.42%
	$ increase	$3.96	($5.30)	($53.84)	$16.33	$27.91	$39.82	$0.00	$8.08	$31.91	$10.18
Employer	Plan Year 2013	$647.16	$1,206.79	$1,307.06	$1,409.74	$1,745.75	$1,756.90	$363.30	$543.93	$543.93	$543.93
	Plan Year 2014	$643.41	$1,212.51	$1,361.49	$1,393.62	$1,718.26	$1,717.67	$384.60	$578.45	$575.89	$576.53
	% increase	-0.58%	0.47%	4.16%	-1.14%	-1.57%	-2.23%	5.86%	6.35%	5.88%	5.99%
	$ increase	($3.75)	$5.71	$54.43	($16.13)	($27.49)	($39.23)	$21.30	$34.53	$31.96	$32.60
Total	Plan Year 2013	**$647.16**	**$1,292.31**	**$1,827.77**	**$1,435.98**	**$2,081.14**	**$2,616.60**	**$363.30**	**$724.57**	**$1,085.18**	**$1,260.02**
	Plan Year 2014	**$647.37**	**$1,292.73**	**$1,828.36**	**$1,436.19**	**$2,081.56**	**$2,617.19**	**$384.60**	**$767.17**	**$1,149.05**	**$1,302.80**
	% increase	0.03%	0.03%	0.03%	0.01%	0.02%	0.02%	5.86%	5.88%	5.89%	3.40%
	$ increase	$0.21	$0.42	$0.59	$0.21	$0.42	$0.59	$21.30	$42.61	$63.87	$42.78

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HSS Subsidy of the '90/10 Contribution Model' CCSF MOU Agreements – Employer pays 90% of employee-only coverage tier. HSS Trust Subsidy bringing the employee-only premium equal to the Kaiser premium for 2014

City Plan (UHC): Final Active/Early Retiree/Medicare Monthly Premium Rates Calendar Year 2014

Exhibit 4
City Plan (UHC) Premium Rates

		Plan Year 2013			Plan Year 2014			
CATEGORY	Open Enrollment 2013 Headcounts	PREMIUM EQUIVALENT	STABILIZATION AMOUNT	TOTAL	PREMIUM EQUIVALENT	STABILIZATION AMOUNT	TOTAL	PERCENTAGE INCREASE
Active EE	719	$1,258.33	$0.64	$1,258.97	$1,274.23	-$46.68	$1,227.55	-2.50%
Active EE + 1	115	$2,472.37	$1.26	$2,473.63	$2,504.17	-$91.72	$2,412.45	-2.47%
Active EE + 2	50	$3,487.99	$1.78	$3,489.77	$3,539.74	-$129.41	$3,410.33	-2.28%
Early Retiree EE	506	$1,465.74	$0.75	$1,466.49	$1,483.34	-$54.37	$1,428.97	-2.56%
Early Retiree EE + 1	184	$2,887.17	$1.47	$2,888.64	$2,922.36	-$107.11	$2,815.25	-2.54%
Early Retiree EE+ 2	15	$3,902.79	$1.99	$3,904.78	$3,956.12	-$144.79	$3,811.33	-2.39%
Medicare Retiree EE	4315	$374.30	$0.19	$374.49	$378.08	-$13.90	$364.18	-2.76%
Medicare Retiree EE + 1	1348	$713.66	$0.36	$714.02	$721.18	-$26.52	$694.66	-2.71%
Medicare Retiree EE + 2	23	$1,729.28	$0.88	$1,730.16	$1,631.13	-$59.99	$1,571.14	-9.19%
	7275	$63,742,000	$32,000	$63,774,000	$64,438,000	-$2,365,000	$62,073,000	-2.67%

Estimated cost increase plan year 2014 -$1,701,000

City Plan (UHC): Final Active/Early Retiree/Medicare Monthly Contributions Calendar Year 2014

Exhibit 5a
Historic CCSF MOU Agreements

		Active (Bargained)			Early Retiree			Medicare Retiree			
		EE	EE+1	EE+2	EE	EE+1	EE+2	EE	EE+1	EE+2 (All Medicare	EE+2
Members	Plan Year 2013	$0.00	$1,204.58	$2,220.72	$362.09	$1,073.17	$2,089.31	$0.00	$169.76	$508.96	$1,185.90
	Plan Year 2014	$0.00	$1,078.05	$2,076.41	$331.50	$1,024.63	$2,022.78	$0.00	$162.97	$474.20	$1,051.94
	% increase	0.00%	-10.50%	-6.50%	-8.45%	-4.52%	-3.18%	0.00%	-4.00%	-6.83%	-11.30%
	$ increase	$0.00	($126.53)	($144.31)	($30.59)	($48.54)	($66.53)	$0.00	($6.79)	($34.76)	($133.96)
Employer	Plan Year 2013	$1,258.97	$1,269.05	$1,269.05	$1,104.40	$1,815.47	$1,815.47	$374.49	$544.26	$544.26	$544.26
	Plan Year 2014	$1,227.55	$1,334.40	$1,333.92	$1,097.47	$1,790.62	$1,788.55	$364.18	$531.69	$529.43	$529.70
	% increase	-2.50%	5.15%	5.11%	-0.63%	-1.37%	-1.48%	-2.75%	-2.31%	-2.73%	-2.67%
	$ increase	($31.42)	$65.35	$64.87	($6.93)	($24.85)	($26.92)	($10.31)	($12.57)	($14.83)	($14.56)
Total	Plan Year 2013	**$1,258.97**	**$2,473.63**	**$3,489.77**	**$1,466.49**	**$2,888.64**	**$3,904.78**	**$374.49**	**$714.02**	**$1,053.22**	**$1,730.16**
	Plan Year 2014	**$1,227.55**	**$2,412.45**	**$3,410.33**	**$1,428.97**	**$2,815.25**	**$3,811.33**	**$364.18**	**$694.66**	**$1,003.63**	**$1,581.64**
	% increase	-2.50%	-2.47%	-2.28%	-2.56%	-2.54%	-2.39%	-2.75%	-2.71%	-4.71%	-8.58%
	$ increase	($31.42)	($61.18)	($79.44)	($37.52)	($73.39)	($93.45)	($10.31)	($19.36)	($49.59)	($148.52)

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Historic CCSF MOU Agreements – Employer pays 100% of employee-only coverage tier

City Plan (UHC): Final Active/Early Retiree/Medicare Monthly Contributions Calendar Year 2014

Exhibit 5b
'90/10 Contribution Model' CCSF MOU Agreements

		Active (Bargained)			Early Retiree			Medicare Retiree			
		EE	EE+1	EE+2	EE	EE+1	EE+2	EE	EE+1	EE+2 (All Medicare	EE+2
Members	Plan Year 2013	$0.00	$1,204.58	$2,220.72	$362.09	$1,073.17	$2,089.31	$0.00	$169.76	$508.96	$1,185.90
	Plan Year 2014	$320.47	$1,078.05	$2,076.41	$331.50	$1,024.63	$2,022.78	$0.00	$162.97	$474.20	$1,051.94
	% increase	0.00%	-10.50%	-6.50%	-8.45%	-4.52%	-3.18%	0.00%	-4.00%	-6.83%	-11.30%
	$ increase	$320.47	($126.53)	($144.31)	($30.59)	($48.54)	($66.53)	$0.00	($6.79)	($34.76)	($133.96)
Employer	Plan Year 2013	$1,258.97	$1,269.05	$1,269.05	$1,104.40	$1,815.47	$1,815.47	$374.49	$544.26	$544.26	$544.26
	Plan Year 2014	$907.08	$1,334.40	$1,333.92	$1,097.47	$1,790.62	$1,788.55	$364.18	$531.69	$529.43	$529.70
	% increase	-27.95%	5.15%	5.11%	-0.63%	-1.37%	-1.48%	-2.75%	-2.31%	-2.73%	-2.67%
	$ increase	($351.89)	$65.35	$64.87	($6.93)	($24.85)	($26.92)	($10.31)	($12.57)	($14.83)	($14.56)
Total	Plan Year 2013	**$1,258.97**	**$2,473.63**	**$3,489.77**	**$1,466.49**	**$2,888.64**	**$3,904.78**	**$374.49**	**$714.02**	**$1,053.22**	**$1,730.16**
	Plan Year 2014	**$1,227.55**	**$2,412.45**	**$3,410.33**	**$1,428.97**	**$2,815.25**	**$3,811.33**	**$364.18**	**$694.66**	**$1,003.63**	**$1,581.64**
	% increase	-2.50%	-2.47%	-2.28%	-2.56%	-2.54%	-2.39%	-2.75%	-2.71%	-4.71%	-8.58%
	$ increase	($31.42)	($61.18)	($79.44)	($37.52)	($73.39)	($93.45)	($10.31)	($19.36)	($49.59)	($148.52)

'90/10 Contribution Model' CCSF MOU Agreements – Employer pays 90% of employee-only coverage tier

City Plan (UHC): Final Active/Early Retiree/Medicare Monthly Contributions Calendar Year 2014

Exhibit 5c
HSS Trust Subsidy of the '90/10 Contribution Model'

		Active (Bargained)			Early Retiree			Medicare Retiree			
		EE	EE+1	EE+2	EE	EE+1	EE+2	EE	EE+1	EE+2 (All Medicare	EE+2
Members	Plan Year 2013	$0.00	$1,204.58	$2,220.72	$362.09	$1,073.17	$2,089.31	$0.00	$169.76	$508.96	$1,185.90
	Plan Year 2014	$3.96	$1,078.05	$2,076.41	$331.50	$1,024.63	$2,022.78	$0.00	$162.97	$474.20	$1,051.94
	% increase	0.00%	-10.50%	-6.50%	-8.45%	-4.52%	-3.18%	0.00%	-4.00%	-6.83%	-11.30%
	$ increase	$3.96	($126.53)	($144.31)	($30.59)	($48.54)	($66.53)	$0.00	($6.79)	($34.76)	($133.96)
Employer	Plan Year 2013	$1,258.97	$1,269.05	$1,269.05	$1,104.40	$1,815.47	$1,815.47	$374.49	$544.26	$544.26	$544.26
	Plan Year 2014	$907.08	$1,334.40	$1,333.92	$1,097.47	$1,790.62	$1,788.55	$364.18	$531.69	$529.43	$529.70
	% increase	-27.95%	5.15%	5.11%	-0.63%	-1.37%	-1.48%	-2.75%	-2.31%	-2.73%	-2.67%
	$ increase	($351.89)	$65.35	$64.87	($6.93)	($24.85)	($26.92)	($10.31)	($12.57)	($14.83)	($14.56)
Total	Plan Year 2013	**$1,258.97**	**$2,473.63**	**$3,489.77**	**$1,466.49**	**$2,888.64**	**$3,904.78**	**$374.49**	**$714.02**	**$1,053.22**	**$1,730.16**
	Plan Year 2014	**$1,227.55**	**$2,412.45**	**$3,410.33**	**$1,428.97**	**$2,815.25**	**$3,811.33**	**$364.18**	**$694.66**	**$1,003.63**	**$1,581.64**
	% increase	-2.50%	-2.47%	-2.28%	-2.56%	-2.54%	-2.39%	-2.75%	-2.71%	-4.71%	-8.58%
	$ increase	($31.42)	($61.18)	($79.44)	($37.52)	($73.39)	($93.45)	($10.31)	($19.36)	($49.59)	($148.52)

HSS Subsidy of the '90/10 Contribution Model' CCSF MOU Agreements – Employer pays 90% of employee-only coverage tier. HSS Trust Subsidy bringing the employee-only premium equal to the Kaiser premium for 2014

VSP Vision: Final Active/Early Retiree/Medicare Monthly Contributions Calendar Year 2014

Exhibit 6
Vision Plan Rates

		Active (Bargained)			Retiree		
		EE	EE+1	EE+2	EE	EE+1	EE+2
Rates	Plan Year 2013	$3.78	$7.58	$10.73	$3.78	$7.58	$10.73
	Plan Year 2014	$3.99	$8.00	$11.32	$3.99	$8.00	$11.32
	% increase	5.5%	5.5%	5.5%	5.5%	5.5%	5.5%
	$ increase	$0.21	$0.42	$0.59	$0.21	$0.42	$0.59

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Delta Dental PPO: Final Active/Retiree Monthly Contributions Calendar Year 2014

Exhibit 7
Dental PPO Plan Rates

		Active (Bargained)			Retiree		
		EE	EE+1	EE+2	EE	EE+1	EE+2
Rates	Plan Year 2013	$63.47	$133.29	$190.42	$39.87	$79.80	$120.54
	Plan Year 2014	$65.95	$138.49	$197.84	$42.37	$84.80	$128.10
	% increase	3.90%	3.90%	3.90%	6.27%	6.27%	6.27%
	$ increase	$2.48	$5.20	$7.43	$2.50	$5.00	$7.56

4251

Delta Care USA : Final Active/Retiree Monthly Contributions Calendar Year 2014

Exhibit 8
Delta HMO Plan Rates

		Active (Bargained)			Retiree		
		EE	EE+1	EE+2	EE	EE+1	EE+2
Rates	Plan Year 2013	$26.00	$42.90	$63.45	$31.70	$52.31	$77.37
	Plan Year 2014	$26.95	$44.46	$65.76	$32.85	$54.21	$80.19
	% increase	3.64%	3.64%	3.64%	3.64%	3.64%	3.64%
	$ increase	$0.95	$1.56	$2.31	$1.15	$1.90	$2.82

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Pacific Union Dental: Final Active/Retiree Monthly Contributions Calendar Year 2014

Exhibit 9
Dental HMO Plan Rates

		Active (Bargained)			Retiree		
		EE	EE+1	EE+2	EE	EE+1	EE+2
Rates	Plan Year 2013	$27.80	$45.90	$67.86	$16.47	$27.20	$40.22
	Plan Year 2014	$27.80	$45.90	$67.86	$16.47	$27.20	$40.22
	% increase	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
	$ increase	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

4253

Life and LTD (Long Term Disability)
Plan Year 2014 Aggregate Costs

Exhibit 10
LTD and Life Plan Rates

Plan Type	Plan Year 2013	Plan Year 2014	% Increase	$ Increase
Basic Life	$316,000	$316,000	$0.00	0.00%
Supplemental Life/Dependent Life	$77,000	$77,000	$0.00	0.00%
Long-Term Disability	$5,687,000	$5,687,000	$0.00	0.00%
Total Annual Estimated Cost	$6,080,000	$6,080,000	$0.00	0.00%

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Distribution of Aggregate Plan Costs ($Millions)

Exhibit 11
Aggregate Costs

TABLE 4 * Distribution of Aggregate Plan Costs ($millions)					
	Member Contributions	Employer Contributions	Aggregate Plan Cost	Member Contributions as a % of Aggregate Costs	Employer Contributions as a % of Aggregate Costs
Kaiser HMO	**$27.2**	**$295.6**	**$322.8**	**8.43%**	**91.57%**
$ Increase	$1.3	$14.7	$16.0		
% Increase	4.93%	5.25%	5.22%		
Blue Shield HMO	**$41.9**	**$266.5**	**$308.5**	**13.60%**	**86.40%**
$ Increase	-$0.1	$1.8	$1.7		
% Increase	-0.23%	0.67%	0.55%		
City Plan	**$11.8**	**$50.3**	**$62.1**	**18.94%**	**81.06%**
$ Increase	$0.7	-$2.4	-$1.7		
% Increase	6.76%	-4.63%	-2.66%		
Dental **	**$3.2**	**$40.7**	**$43.9**	**7.38%**	**92.62%**
$ Increase	$0.0	$1.6	$1.6		
% Increase	0.00%	2.68%	2.48%		
LTD	**$0.0**	**$5.7**	**$5.7**	**0.00%**	**100.00%**
$ Increase	$0.0	$0.0	$0.0		
% Increase	0.00%	0.00%	0.00%		
Life	**$0.1**	**$0.3**	**$0.4**	**19.55%**	**80.45%**
$ Increase	$0.0	$0.0	$0.0		
% Increase	0.00%	0.00%	0.00%		
Total	**$84.2**	**$659.1**	**$743.3**	**11.33%**	**88.67%**
$ Increase	$1.9	$15.7	$17.6		
% Increase	2.34%	2.44%	2.43%		

* Figures vary due to rounding

** Dental costs are for active employees only, retirees and surviving spouses have not been included

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Distribution of Aggregate Plan Costs ($Millions) Including Impact of HSS Trust Subsidy

Exhibit 12
Aggregate Costs with HSS Trust Subsidy

Distribution of Aggregate Plan Costs ($millions)						
	Member Contributions	HSS Trust Subsidy	Employer Contributions	Aggregate Plan Cost	Member Contributions as a % of Aggregate Costs	Employer Contributions as a % of Aggregate Costs
Kaiser HMO	**$27.2**	**$0.0**	**$295.6**	**$322.8**	**8.43%**	**91.57%**
$ Increase	$1.3	$0.0	$14.7	$16.0		
% Increase	4.93%	0.00%	5.25%	5.22%		
Blue Shield HMO	**$39.9**	**$2.0**	**$266.5**	**$308.5**	**12.95%**	**86.40%**
$ Increase	-$2.1	$2.0	$1.8	$1.7		
% Increase	-4.99%	0.00%	0.67%	0.55%		
City Plan	**$10.4**	**$1.4**	**$50.3**	**$62.1**	**16.68%**	**81.06%**
$ Increase	-$0.7	$1.4	-$2.4	-$1.7		
% Increase	-5.95%	0.00%	-4.63%	-2.66%		
Dental **	**$3.2**	**$0.0**	**$40.7**	**$43.9**	**7.38%**	**92.62%**
$ Increase	$0.0	$0.0	$1.6	$1.6		
% Increase	0.00%	0.00%	2.68%	2.48%		
LTD	**$0.0**	**$0.0**	**$5.7**	**$5.7**	**0.00%**	**100.00%**
$ Increase	$0.0	$0.0	$0.0	$0.0		
% Increase	0.00%	0.00%	0.00%	0.00%		
Life	**$0.1**	**$0.0**	**$0.3**	**$0.4**	**19.55%**	**80.45%**
$ Increase	$0.0	$0.0	$0.0	$0.0		
% Increase	0.00%	0.00%	0.00%	0.00%		
Total	**$80.8**	**$3.4**	**$659.1**	**$743.3**	**10.87%**	**88.67%**
$ Increase	($1.5)	$3.4	$15.7	$17.6		
% Increase	-1.79%	0.00%	2.44%	2.43%		

* Figures vary due to rounding

** Dental costs are for active employees only, retirees and surviving spouses have not been included

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Aggregate Medical Costs ($Millions) Including Impact of HSS Trust Subsidy

Exhibit 13
HSS Trust Subsidy

January 1, 2014 to December 31, 2014 Aggregate Medical Cost ($ millions)				
	Member Contributions	Employer Contributions	HSS Trust Subsidy	Aggregate Plan Cost
Current Rates	**$79.0**	**$598.3**	**N/A**	**$677.3**
Final Renewal Rates (including plan design changes)	**$77.5**	**$612.4**	**$3.4**	**$693.3**
$ Difference	($1.5)	$14.1	$3.4	$16.0
% Difference	-1.90%	2.36%	N/A	2.36%

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CITY AND COUNTY OF SAN FRANCISCO
MEMBERSHIP ENROLLMENT STATISTICS REPORT

MEDICAL PLAN ENROLLMENT

MEMBERSHIP STATUS	CTYPLN	BLSHLD	BLSHLD ACCESS+	KAISER	WAIVED	TOTAL
ACTIVE Members	869	16,050	0	18,912	1,992	37,823
NO MEDICARE	869	16,050	0	18,912	1,992	37,823
MEDICARE A						
MEDICARE B						
MEDICARE AB						
RETIRED Members	5,236	3,514	3,489	10,143	1,794	24,176
NO MEDICARE	568		2,475	2,421	1,235	6,699
MEDICARE A	-	-	-	-	-	17
MEDICARE B	38		45	49	-	133
MEDICARE AB	4,605	3,514	966	7,673	546	17,304
NON-COMPLIANT	23	-	-	-	-	23
SURVIVING SPOUSE	1,027	245	203	1,284	362	3,121
NO MEDICARE	61		127	190	208	586
MEDICARE A						
MEDICARE B	-		-	-	-	8
MEDICARE AB	963	245	74	1,092	152	2,526
NON-COMPLIANT	-					1
COMMISSIONERS	-	40	0	29	150	223
NO MEDICARE	-	40	0	29	150	223
MEDICARE A						
MEDICARE B						
MEDICARE AB						
TOTAL MEMBERS	7,136	19,849	3,692	30,368	4,298	65,343

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MEDICAL PLAN ENROLLMENT

MEMBERSHIP STATUS	CTYPLN	BLSHLD	BLSHLD ACCESS+	KAISER	WAIVED	TOTAL
SPOUSE/DOM PRT DEPENDENTS OF ACTIVE Members	135	6,399	0	7,570	0	14,104
NO MEDICARE	134	6,369	0	7,541	0	14,044
MEDICARE A						
MEDICARE B		-	-	-	0	1
MEDICARE AB	-	29	-	29	0	59
SPOUSE/DOM PRT DEPENDENTS OF RETIRED Members	1,493	1,075	1,269	3,212	0	7,049
NO MEDICARE	291	330	891	1,194		2,706
MEDICARE A	-	-	-	-	0	2
MEDICARE B	-	-	-	-	0	21
MEDICARE AB	1,196	742	373	2,008		4,319
NON-COMPLIANT	-	-	-	-	0	1
SPOUSE/DOM PRT DEPENDENTS OF SURVIVING SPOUSE	0	0	0	0	0	0
NO MEDICARE						
MEDICARE A						
MEDICARE B						
MEDICARE AB						
NON-COMPLIANT						
SPOUSE/DOM PRT DEPENDENTS OF COMMISSIONERS	-	-	0	-	0	15
NO MEDICARE	-	-	0	-	-	15
MEDICARE A						
MEDICARE B						
MEDICARE AB						

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MEDICAL PLAN ENROLLMENT

MEMBERSHIP STATUS	CTYPLN	BLSHLD	BLSHLD ACCESS+	KAISER	WAIVED	TOTAL
CHILD/MINOR DEPENDENTS OF ACTIVE Members	113	10,714	0	13,783	0	24,610
NO MEDICARE	113	10,713	0	13,782		24,608
MEDICARE A						
MEDICARE B						
MEDICARE AB		-		-		2
CHILD/MINOR DEPENDENTS OF RETIRED Members	73	130	645	635	0	1,483
NO MEDICARE	68	126	643	621		1,458
MEDICARE A						
MEDICARE B						
MEDICARE AB	-	-	-	-		25
NON-COMPLIANT						
CHILD/MINOR DEPENDENTS OF SURVIVING SPOUSE	-	-	31	41	0	79
NO MEDICARE	-	-	31	39		76
MEDICARE A						
MEDICARE B						
MEDICARE AB	-			-		3
NON-COMPLIANT						
CHILD/MINOR DEPENDENTS OF COMMISSIONERS	-	-	-	-	0	19
NO MEDICARE	-	-		-		19
MEDICARE A						
MEDICARE B						
MEDICARE AB						
TOTAL DEPENDENTS	1,826	18,341	1,945	25,247	0	47,359
MEDICAL PLAN TOTALS	8,962	38,190	5,637	55,615	4,298	112,702

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DENTAL PLAN ENROLLMENT

MEMBERSHIP STATUS	DLTDEN	DLCDEN	PUDDEN	WAIVED	TOTAL
ACTIVE Members	26,813	700	359	1,165	29,037
RETIRED Members	14,572	1,151	573	7,982	24,278
SURVIVING SPOUSE	1,400	190	58	1,475	3,123
COMMISSIONERS	51	-	-	163	223
TOTAL MEMBERS	42,836	2,049	991	10,785	56,661
SPOUSE/DOM PRT DEPENDENTS OF ACTIVE Members	13,551	269	151	0	13,971
SPOUSE/DOM PRT DEPENDENTS OF RETIRED Members	5,738	442	196	0	6,376
SPOUSE/DOM PRT DEPENDENTS OF SURVIVING SPOUSE					
SPOUSE/DOM PRT DEPENDENTS OF COMMISSIONERS	-	-	-	0	20
CHILD/MINOR DEPENDENTS OF ACTIVE Members	23,744	494	239	0	24,477
CHILD/MINOR DEPENDENTS OF RETIRED Members	1,466	104	45	0	1,615
CHILD/MINOR DEPENDENTS OF SURVIVING SPOUSE	93	-	-	0	109
CHILD/MINOR DEPENDENTS OF COMMISSIONERS	-	-	-	0	21
TOTAL DEPENDENTS	44,631	1,319	639	0	46,589
DENTAL PLAN TOTALS	87,467	3,368	1,630	10,785	103,250

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CITY AND COUNTY OF SAN FRANCISCO
MEMBERSHIP ENROLLMENT STATISTICS REPORT

LTD, LIFE AND FSA PLAN ENROLLMENT

MEMBERSHIP STATUS	LTD	LIFE	DEPFSA	HTHFSA
ACTIVE Members	20,521	6,124	790	2,438

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orig: B/F clerk
B/F chair, BOS-11, COB
Leg Dep.

President, District 3
BOARD of SUPERVISORS

City Hall
1 Dr. Carlton B. Goodlett Place, Room 244
San Francisco 94102-4689
Tel. No. 554-7450
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TDD/TTY No. 544-5227

DAVID CHIU
邱信福
市參事會主席

PRESIDENTIAL ACTION

RECEIVED
BOARD OF SUPERVISORS
SAN FRANCISCO
2013 JUL -2 PM 12:50

Date: 7-2-13

To: Angela Calvillo, Clerk of the Board of Supervisors

Madam Clerk,

Pursuant to Board Rules, I am hereby:

☑ Waiving 30-Day Rule (Board Rule No. 3.23)

File No. 130653 Farrell
(Primary Sponsor)

☐ Transferring (Board Rule No. 3.3)

File No. _____ _____
(Primary Sponsor)

From: _____ Committee

To: _____ Committee

☐ Assigning Temporary Committee Appointment (Board Rule No. 3.1)

Supervisor _____

Replacing Supervisor _____

For: _____, _____ Meeting
(Date) (Committee)

David Chiu

David Chiu, President
Board of Supervisors

Board of Supervisors

Approval of Health Service System Rates and Benefits for Plan Year 2014

July 10, 2013

4265

Health Service System Trust

The Health Service System Trust provides health care benefits for four employers:

- San Francisco Unified School District
- San Francisco Community College District
- Superior Court of San Francisco
- City and County of San Francisco

This 2014 Rates and Benefits packet represents employee and retiree benefits for all four participating employers

4266

- Aggregate and CCSF Premium Increases
- Affordable Care Act Fees and Taxes
- Medical Plans: Blue Shield, City Plan, Kaiser
- Kaiser Negotiation Process
- HSS Recommendations
- Implications of Non-Approval
- Suggested Action Plan

4267

2.43% Aggregate Premium Increase

Aggregate data for all four employers (Millions)	Members Pay	Employers Pay	Total Cost	Year over Year % Increase
Kaiser HMO	$27.2M	$295.6M	$322.8M	5.22%
Blue Shield HMO	$42.0M	$266.5M	$308.5M	0.55%
City Plan PPO	$11.8M	$50.3M	$62.1M	-2.66%
Dental Plans	$3.2M	$40.7M	$43.9M	2.48%
Long Term Disability	$0	$5.7M	$5.7M	0%
Life	$0.1M	$0.3M	$0.4M	0%
TOTAL	**$84.2M**	**$659.1M**	**$743.3M**	**2.43%**

In 2014, premium costs will increase by 17.6M (2.43%) to 743.3M.
Employers pay 88.7% ($659.1M) and members pay 11.3% ($84.2M) of these premiums.

4268

Affordable Care Act (ACA)

2014 ACA FEES and TAXES (estimated by Aon Hewitt)		
Patient-Centered Outcomes Research Institute	Direct Fee	$.24M
Transitional Re-insurance Program	Direct Fee	$5.49M
Health Insurance Industry Tax	Excise Tax	$10.91M
TOTAL		**$16.65M**

2.29% of the 2.43% 2014 premium increase is attributable to ACA fees and taxes.

Additional ACA pharmaceutical and medical device excises taxes will be paid by plan vendors and passed on in future premium increases.

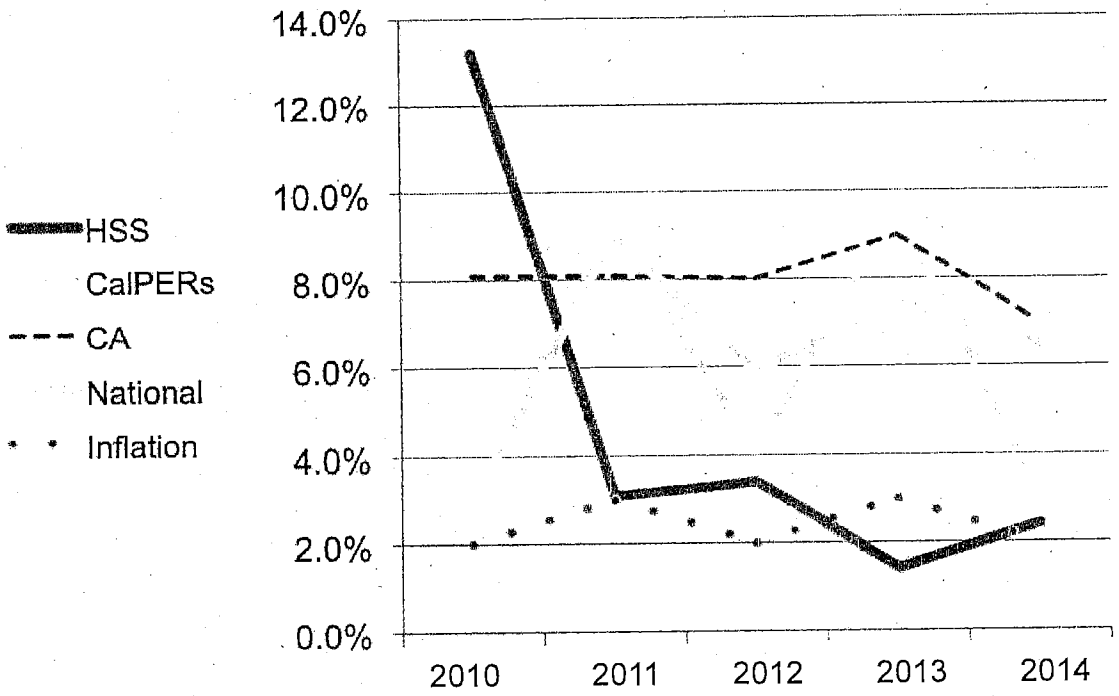
4269

Medical Plans: 2014 Increases

BLUE SHIELD	CITY PLAN	KAISER
.55% year-over-year premium increase	-2.66% year-over-year premium reduction	5.22% year-over-year premium increase
3.2% ACA taxes and fees	.24% ACA taxes and fees	1.77% ACA taxes and fees
-2.65% premium reduction	-2.9% premium reduction	3.45% premium increase
$20M savings from flex-funding $3-4M savings from lower utilization trends due to ACOs	$16M savings from lower utilization trends, federal drug subsidies, and improved management	$9.3M increase (not including ACA fees and taxes)

Aggregate premium data for all four employers

HSS Is Beating Healthcare Cost Trends



Year-over-Year Aggregate Medical Cost Increases

- Reduced City's projected costs by $52.6M for 2013-14 and 2014-15.
- Mitigates City's long-term commitments and GASB 45 projections.
- Negotiated 2014 aggregate 2.4% medical cost increase; 2.3% due to federal health care reform fees and taxes.
- Helps realize goal of sustainable, affordable healthcare now and into the future.

4271

Beating the Trends

Due to aggressive cost containment strategies, HSS has beat national, state and regional trends in health premium increases for the past three benefits periods:

- **3.1%** aggregate premium increase in FY 2011-12. Over 25M saved from RFP and benefit changes.
- **3.6%** annualized aggregate premium increase in calendar year 2012 (based on July-Dec short plan year). Over 18M saved from calendar year change and benefit changes
- **1.4%** aggregate premium increase in calendar year 2013. Over 40M saved from flex-funding, ACO efforts, etc.
- **2.4%** aggregate increase in 2014 of which 2.3% was due to Healthcare Reform fees and Taxes.

4272

0.7% City & County Premium Increase

Data for just CCSF (Millions)	2013	2014	Increase	Year over Year
City Premiums	$517.6M	$523.1M	$5.5	1.1%
Member Premiums	$74.1M	$72.6M	-$1.5	-2.0%
TOTAL	**$591.7M**	**$595.8M**	**$4.1**	**0.7%**

4273

City & County of San Francisco members will pay 2% less in premiums in 2014 compared to 2013, due primarily to decreases in Blue Shield and City Plan premium rates.

Aon Hewitt data for CCSF; includes medical, dental, vision, LTD and life.

Flat Premium Incentive

At the June meeting of the Health Service Board, the Board approved an additional rate card for the two self-insured plans, Blue Shield and City Plan.

This Card provides a subsidy from the HSS Trust Fund to bring the 2014 Employee Only Contribution to the same Employee Contribution as Kaiser.

This rate card will apply to any member whose union agrees to a Flat Premium contribution strategy by 7/31/13.

4274

Plan	Employee Only 90/10 Rate	Employee Only HSS Subsidized Rate
Blue Shield	$60.17	$3.96
City Plan	$320.97	$3.96

Maximum HSS 2014 subsidy if all unions agree to Flat Premium = $3.4M.

Kaiser Negotiation Process

Substantial efforts were made to date to engage Kaiser in negotiations, but there was no movement on proposed 2014 rates.

- Six meetings between Health Service System executives, Aon Hewitt consultants and Kaiser representatives since January 2013.
- Numerous telephone conferences.
- Two Health Service Board meetings between January to June 2013.
- Public comments by representatives from the Mayor's office and labor leaders.
- Discussions with other large employers that contract with Kaiser.

4275

HSS Recommendations

The Health Service Board, the Health Service System and the Board of Supervisors Legislative Analyst recommend approval of 2014 rates and benefits.

- Realize the 2.43% aggregate and .7% City rate increases for 2014
- Preserve continuity of care and avoid disruption of medical services for over 40,000 Kaiser enrollees
- Meet federal deadlines for communicating plan and rate information during Open Enrollment
- Immediately engage in Kaiser action plan for 2015
- Pursue cost-competitive alternatives to Kaiser for 2015

4276

Implications of Not Approving Rates

PROCEDURAL

- To exclude Kaiser, new actuarial analysis is mandated; will take until August to complete
- Health Service Trust takes on more risk (all plans self-insured)
- Update assessment of impact on City budget and GASB
- Board of Supervisors August meeting to review alternative proposals and approve plans and rates
- Delay in approval beyond August will push back Open Enrollment

MEMBER DISRUPTION

- 40,000+ Kaiser members would need to move to either Blue Shield or City Plan and find new physicians
- ACA is expected to also cause large influx of patients in 2014
- State law does offer continuity of care protection in certain cases
- Utilization typically increases in first year of disruption as it can take several months to transfer medical records
- Typically takes six months of communications to prepare for large disruption

4277

Proposed Draft Action Plan

HEALTH SERVICE SYSTEM

- Immediately commence 2015 Kaiser negotiations
- Evaluate Kaiser self-insurance and shared risk options
- Consider risk adjusted premiums to equalize risk rating among plans
- Prepare contingency options for cost-competitive alternatives and/or moving away from Kaiser in 2015

BOARD OF SUPERVISORS

- Transparency legislation for all medical plans that contract with the City
- Require regular updates on ongoing 2015 Kaiser negotiations
- Support transparency legislation on state and county levels
- Call for profit pledge commitment from all health plans contracted with the City

UNIONS

- Support Transparency legislation efforts
- Voluntary Kaiser boycott during October Open Enrollment
- Pursue premium contribution models that do not favor Kaiser
- Keep members informed about ongoing 2015 Kaiser negotiations
- Legislative lobbying

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City and County of San Francisco

Budget and Finance Sub-Committee Meeting

JUNE 14, 2016

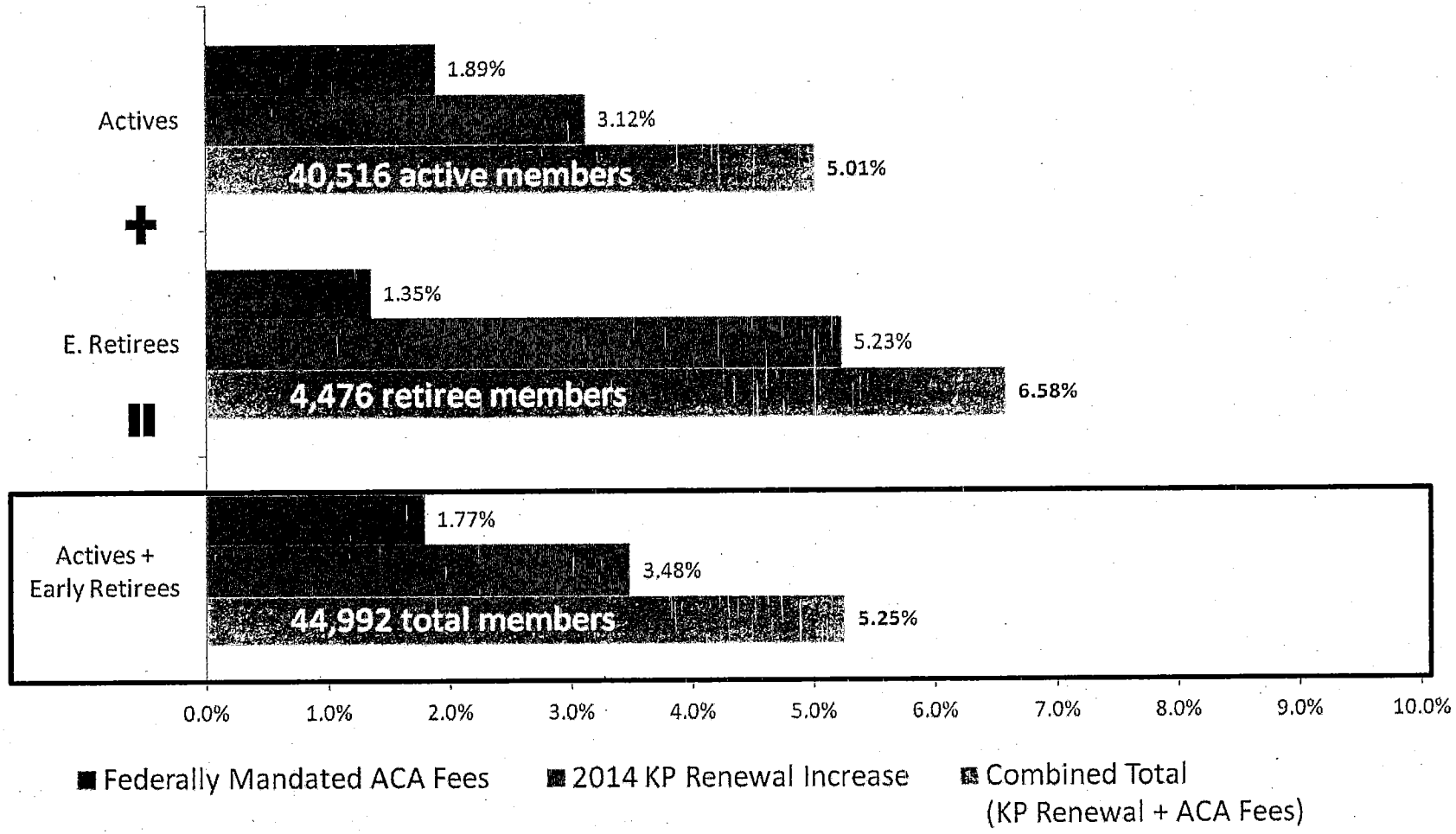
KAISER PERMANENTE® thrive

Agenda

- The 2014 Renewal Increase
  - Rate History and Market Trends
- 2015 KP Renewal Commitment to HSS
- KP's Commitment and Performance Guarantees
  - Accountability
  - Transparency
  - Wellness
- What if KP is Not Renewed?
- Year-Round Reporting and Transparency

4280

2014 HSS Renewal Increase Calculation and Overview



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KAISER PERMANENTE® thrive

Year-over-Year Changes in Claims, 2011-2012

- HSS Actives → 5.5%
- HSS Early Retirees → 8.7%

- HSS Total → 5.6%

- KP Average → 5.8%

4282

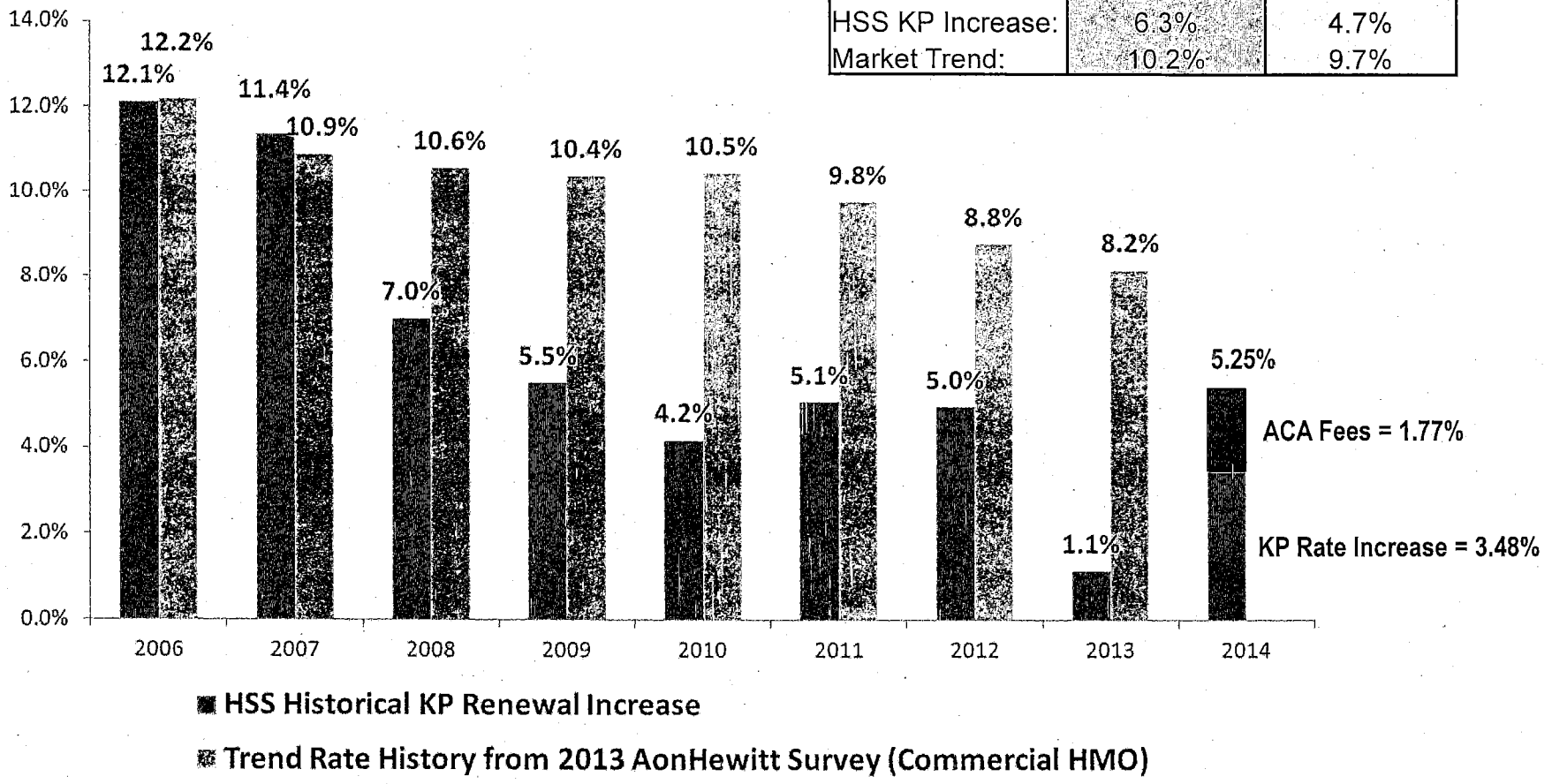
2014 Renewal Primary Rate Drivers

- Use 2012 HSS utilization data including:
  - Inpatient and outpatient surgeries and procedures, hospital admissions, mental health and substance abuse, emergency room visits, maternity, laboratory, radiology, pharmacy including generic/brand, durable medical equipment
  - Adjusted for demographics including gender and age
- Trend data forward to project utilization in 2014
- Administration charge
- New for 2014 ACA Fees

4283

HSS Rate Renewal History vs. Market Trend

	Average Increases	
	2006 – 2013	2008 – 2013
HSS KP Increase:	6.3%	4.7%
Market Trend:	10.2%	9.7%



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KAISER PERMANENTE thrive

2014 Renewal Summary

- The rates reflect Kaiser Permanente's expected claims and administrative expenses for providing care to the City & County of San Francisco employees, retirees and their families

- We use the same group-specific experience rating methodology for all of our large group customers

4285

2015 KP Renewal Commitment to HSS

- KP is committed to:
  - Beginning discussions immediately
  - Defining mutually clear objectives
  - Analyzing alternative funding methodologies
  - Working towards a mutually successful renewal

4286

KP's Commitment and Performance Guarantee

KP has committed to providing:

- Transparency
  - Monthly KP/HSS claims data feed to be provided to a HSS third-party data repository
  - Data files on member risk scores and quality indicators bi-annually
- Accountability
  - A performance guarantee on the management of chronic health conditions based on both financial and clinical metrics
- Wellness
  - In partnership with HSS, develop a multi-year wellness program. Specifically for 2014, the program will include both on-site weekly bio metric screenings and seasonal flu clinics (Fall)
  - Partner in a Kaiser funded research study evaluating wellness effectiveness for our HSS members
  - Details on each of these will be worked out with HSS

What if Kaiser Permanente is Not Renewed?

- In response to the Board meeting on 7/10/13, we want to convey what happens if KP is not renewed

- Based on the Controller's statement last week, HSS and KP must have a contract in place effective 1/1/2014, for HSS to reimburse KP for services rendered

- If the Board of Supervisors doesn't renew the KP contract, KP would need to work with HSS over the next five months to transition the care of KP members to other providers

4288

Year-Round Reporting and Transparency

Report Title/ Type	Data Provided	Frequency	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Chronic Condition Report	Member health, showing prevalence and cost of five major chronic conditions	Annually											✓	✓
Dashboard	KP performance including demographics, claims and clinical data	Quarterly	✓			✓			✓			✓		
Online Usage Report (KP.org)	Members use of kp.org as a channel for accessing healthcare resources, information and services	Annually												✓
Performance Guarantees	KP puts 2% of HSS' premium at risk for the performance of our health plan	Annually												✓
Periodic Utilization and Review Report	Cost and utilization trends compared to KP Book of Business	Quarterly		✓			✓			✓			✓	
Prevention and Lifestyle Risk Report	Prevalence of lifestyle and medical risk factors; e.g. smokers	Annually											✓	
Renewal Packet	Rate build up showing group demographics, claims, trend	Annually				✓								
Value Summary Report	Shows how KP's integrated delivery system services provide successful outcomes	Annually			✓									

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APPENDIX

Detailed Rate Build-Up Calculations

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2014 Renewal Calculation

	Medical Calculation		2014 Renewal Actives Factor	2014 Renewal Actives PMPM$	2014 Renewal Early Retirees (North) Factor	2014 Renewal Early Retirees (North) PMPM$
	Rating Members		40,516		Rating Members	4,476
A1	Paid Claims			$ 380.845		$ 727.888
A2	- Pooling Credit @ $550,000			$ (5.478)		$ (8.046)
A3	+ Pooling Charge			$ 6.940		$ 6.940
A4	**Claims Net of Pooling**			**$ 382.307**		**$ 726.782**
A5	x Incurred Claim Adjustment		1.01056		0.99936	
A6	x Demographic Change		1.00009		0.99390	
A7	x Historical Benefit Change		0.99774		0.99780	
A8	**Adjusted Claims**			**$ 385.506**		**$ 720.297**
A9	x Trend Factor	Annual Trend: 6.21% / 6.18%	1.12809		1.12748	
A10	**Claims Based PMPM**			**$ 434.886**		**$ 812.121**

	Total Rate Calculation	2014 Renewal Actives Factor	2014 Renewal Actives PMPM$	2014 Renewal Early Retirees (North) Factor	2014 Renewal Early Retirees (North) PMPM$	2014 Renewal Averaged
						Rating Members 44,992
D1	Claims Based PMPM		$ 434.886		$ 812.121	
D2	x Future Benefit Change	1.00000		1.00000		
D3	**Adjusted PMPM**		**$ 434.886**		**$ 812.121**	
D4	+ Retention		$ 24.970		$ 24.970	
D5	+ Other Benefits		$ 1.800		$ 1.800	
D6	+ Group Specific Charge		$ -		$ 21.180	
D7	+ Federal Health Insurer Fee		$ 3.056		$ 5.662	
D8	+ Federal PCORI Fee/Transitional Reinsurance Program Contribution		$ 5.420		$ 5.420	
D9	**PMPM Premium Requirement**		**$ 470.132**		**$ 871.153**	
E1	Inforce Rate		$ 449.264		$ 818.897	$ 486.037
E2	Quoted Rate PMPM before Underwriter Adjustment		$ 470.132		$ 871.151	$ 510.027
E3	x Underwriter Adjustment	1.00348		1.00187		1.00321
E4	**Quoted Rate PMPM after Underwriter Adjustment**	**5.01%**	**$ 471.768**	**6.58%**	**$ 872.786**	**5.25%** **$ 511.663**

A1: Paid Claims - Paid medical and pharmacy expenses for services provided to a health plan member during the experience period, reduced for member cost sharing such as copayments and deductibles.

A2-A3: Pooling – In order to protect customers from large rate swings from year to year we credit all claims incurred by an individual, over the experience period, that exceeded the prescribed threshold. There is a corresponding charge for this pooling threshold that allows for this level of protection.

A5-A7: Aggregate Rating Adjustments – In order to reflect the most current group specific information we adjust the claims experience for changes in demographics, Benefits, and to convert claims from paid to incurred.

A8: Trend Factor – The factor applied to a group's historical claims to project future medical expenses.

D4: Retention – The portion of premium that is retained by KP to cover Health Plan administrative expenses such as billing, member services and marketing.

D6: Group Specific Charge – The Charge on the Early Retirees reflects the additional revenue required to provide a single blended rate for the over 65 Unassigned category.

D7-D8: ACA Fees – Fees associated with the recent legislation on the Affordable Care Act.

E3: Underwriter Adjustment – Remaining load to account for costs associated with SB946 Autism Spectrum Disorder.

4292

Actives, 2013 vs. 2014, Renewal Calculation

		2013 Renewal Actives		2014 Renewal Actives		Δ 2013 to 2014 % Change	
		Rating Members	38,492	Rating Members	40,516		
	Medical Calculation	Factor	PMPM$	Factor	PMPM$	Factor	PMPM$
A1	Paid Claims		$ 361.146		$ 380.845		5.5%
A2	- Pooling Credit @ $550,000		$ (9.130)		$ (5.478)		-40.0%
A3	+ Pooling Charge		$ 6.610		$ 6.940		5.0%
A4	**Claims Net of Pooling**		**$ 358.626**		**$ 382.307**		**6.6%**
A5	x Incurred Claim Adjustment	1.01308		1.01056		-0.2%	
A6	x Demographic Change	1.00076		1.00009		-0.1%	
A7	x Historical Benefit Change	0.99587		0.99774		0.2%	
A8	**Adjusted Claims**		**$ 362.092**		**$ 385.506**		**6.5%**
A9	x Trend Factor	1.15708		1.12809		-2.5%	
A10	**Claims Based PMPM**		**$ 418.969**		**$ 434.886**		**3.8%**
	Total Rate Calculation	Factor	PMPM$	Factor	PMPM$	Factor	PMPM$
D1	Claims Based PMPM		$ 418.969		$ 434.886		3.8%
D2	x Future Benefit Change	1.00147		1.00000		-0.1%	
D3	**Adjusted PMPM**		**$ 419.585**		**$ 434.886**		3.6%
D4	+ Retention		$ 24.480		$ 24.970		2.0%
D5	+ Other Benefits		$ 1.800		$ 1.800		0.0%
D6	+ Group Specific Charge		$ -		$ -		N/A
D7	+ Federal Health Insurer Fee		$ -		$ 3.056		N/A
D8	+ Federal PCORI Fee/Transitional Reinsurance Program Contribution		$ -		$ 5.420		N/A
D9	**PMPM Premium Requirement**		**$ 445.865**		**$ 470.132**		5.4%
E1	Inforce Rate		$ 447.758		$ 449.264		0.0%
E2	Quoted Rate PMPM before Underwriter Adjustment		$ 445.865		$ 470.132		5.4%
E3	x Underwriter Adjustment	1.00736		1.00348		-0.4%	
E4	**Quoted Rate PMPM after Underwriter Adjustment**	**0.31%**	**$ 449.150**	**5.01%**	**$ 471.768**		5.0%

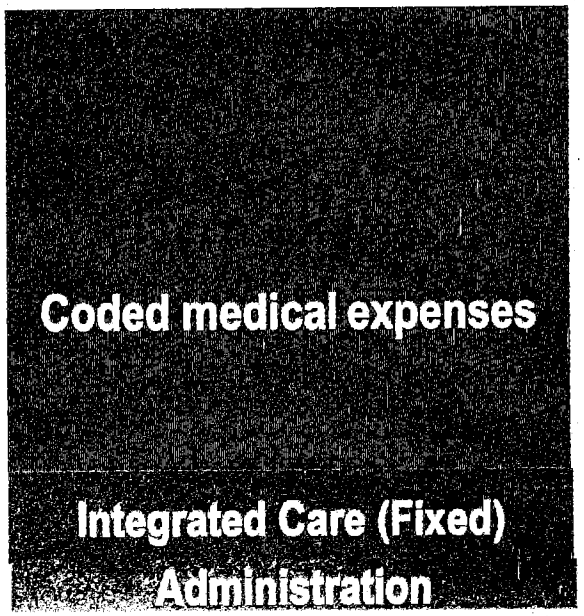
4293

Early Retirees, 2013 vs. 2014, Renewal Calculation

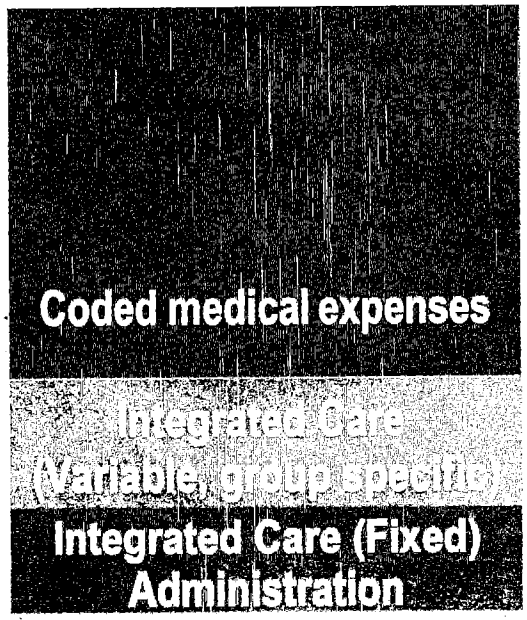
		2013 Renewal Early Retirees		2014 Renewal Early Retirees		Δ 2013 to 2014 % Change	
		Rating Members	4,590	Rating Members	4,476		
	Medical Calculation	Factor	PMPM$	Factor	PMPM$	Factor	PMPM$
A1	Paid Claims		$ 669.621		$ 727.888		8.7%
A2	- Pooling Credit @ $550,000		$ (8.013)		$ (8.046)		0.4%
A3	+ Pooling Charge		$ 6.610		$ 6.940		5.0%
A4	**Claims Net of Pooling**		**$ 668.218**		**$ 726.782**		**8.8%**
A5	x Incurred Claim Adjustment	1.02110		0.99936		-2.1%	
A6	x Demographic Change	0.99416		0.99390		0.0%	
A7	x Historical Benefit Change	0.99603		0.99780		0.2%	
A8	**Adjusted Claims**		**$ 675.637**		**$ 720.297**		**6.6%**
A9	x Trend Factor	1.15603		1.12748		-2.5%	
A10	**Claims Based PMPM**		**$ 781.057**		**$ 812.121**		**4.0%**
	Total Rate Calculation	Factor	PMPM$	Factor	PMPM$	Factor	PMPM$
D1	Claims Based PMPM		$ 781.057		$ 812.121		4.0%
D2	x Future Benefit Change	1.00147		1.00000		-0.1%	
D3	**Adjusted PMPM**		**$ 782.206**		**$ 812.121**		**3.8%**
D4	+ Retention		$ 24.480		$ 24.970		2.0%
D5	+ Other Benefits		$ 1.800		$ 1.800		0.0%
D6	+ Group Specific Charge		$ 18.027		$ 21.180		17.5%
D7	+ Federal Health Insurer Fee		$ -		$ 5.662		N/A
D8	+ Federal PCORI Fee/Transitional Reinsurance Program Contribution		$ -		$ 5.420		N/A
D9	**PMPM Premium Requirement**		**$ 826.513**		**$ 871.153**		5.4%
E1	Inforce Rate		$ 789.576		$ 818.897		1.3%
E2	Quoted Rate PMPM before Underwriter Adjustment		$ 826.513		$ 871.151		5.4%
E3	x Underwriter Adjustment	1.00386		1.00187		-0.2%	
E4	**Quoted Rate PMPM after Underwriter Adjustment**	**5.08%**	**$ 829.700**	**6.58%**	**$ 872.786**		6.7%

4294

Integrated Care Management Services



Previous Renewal



2014 Renewal

- These are services that are instrumental in delivering the highest quality care in the market
- For Kaiser Permanente, these are not billable services
- Expenses shifted from the fee schedule into the separate fee for 2014 renewal
- For more details on each one of these areas, please see the following slides

4295

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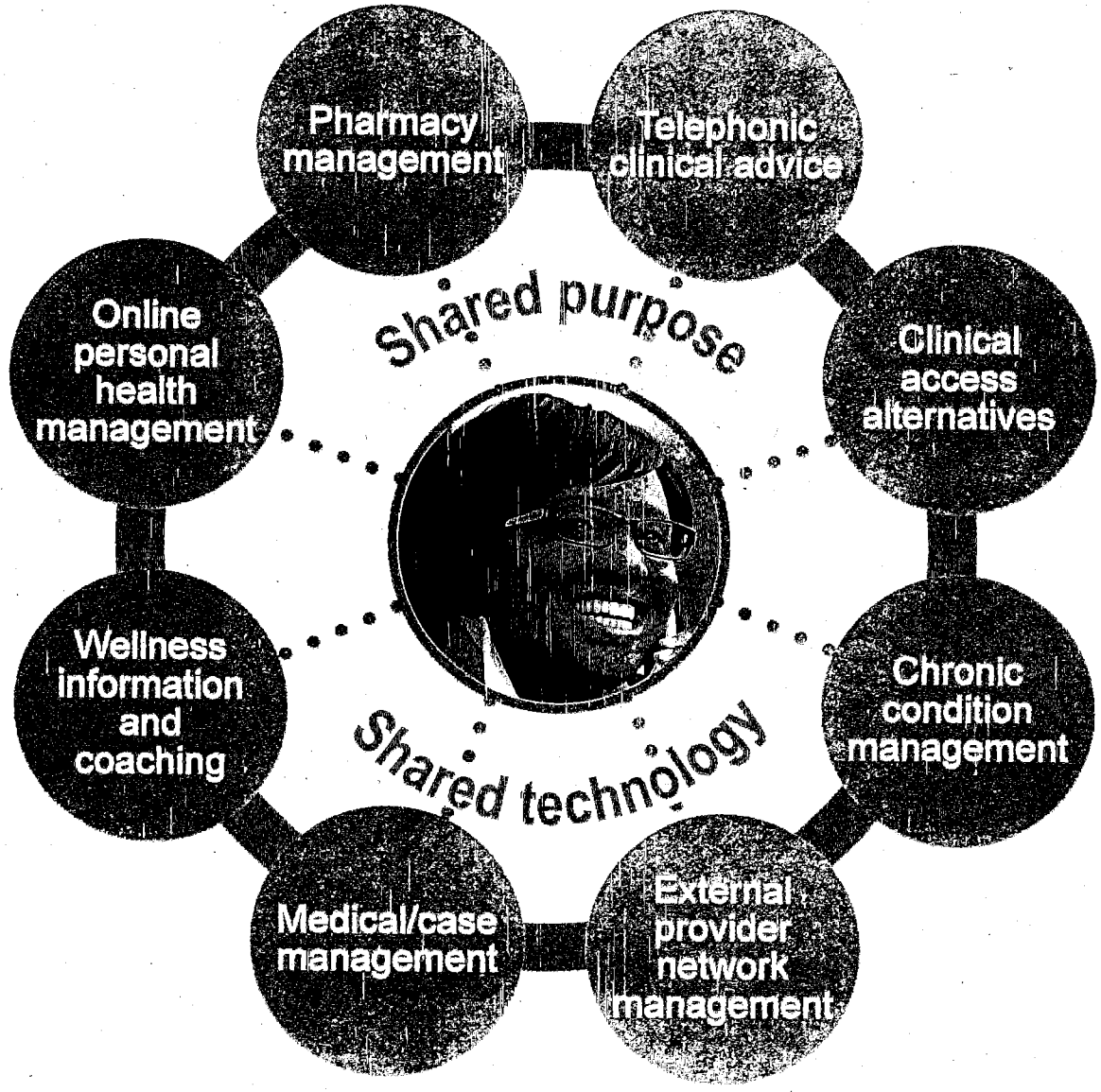
Integrated Care Management Services



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Clinical Access Alternatives

ICM Service	Description
Secure email correspondence with physician/physician's office	Members can email their doctor's office with nonurgent questions—often saving an appointment and a trip to the medical office, as well as a copay. Most other health plans charge members a copay for electronic messaging, if it's covered at all.
Scheduled phone calls with physicians and staff	Scheduled phone visits with caregivers can save members an office visit.
Electronic specialist consults (doctor to doctor)	E-consults between primary care physicians and specialists help resolve questions or advance treatment before specialist visits. The e-consult enables the primary care physician to order any necessary tests or exams before the member sees the specialist, reducing extra visits and making the care experience more fluid and effective, leading to a quicker result.
Phone specialist consults (primary care physician, member, specialist)	When needed during a member's primary care visit, a physician can call a specialist to evaluate the patient's symptoms and immediately resolve the issue or determine if tests are needed or a specialist visit should be scheduled.
Ongoing specialist-to-primary care physician communication	Following patient evaluations, primary care physicians and specialists can view each other's electronic treatment notes in real time and on an ongoing basis. This allows for a thorough and accurate exchange of information.

Chronic Conditions Management

CM Service	Description
Development of evidence-based chronic condition programs	Includes creation/identification of best practices and registry development for our award-winning chronic condition and disease management programs. Programs include: asthma, cancer, coronary heart failure, depression, diabetes, hypertension, chronic pain, chronic obstructive pulmonary disease, coronary artery disease, high-risk maternity, HIV/AIDS, neonatal complications, and obesity. Other health plans contract with third-party disease management vendors with limited ability to integrate with the clinical care experience.
Case identification and automatic enrollment	Includes disease registries and built-in system alerts that automatically identify at-risk members. If a chronic condition is diagnosed, the member is automatically enrolled in the appropriate program. Third-party disease management programs have limited connection to the care experience, so patients have to opt in, may require health plan authorization, and may incur additional costs.

4298

Chronic Conditions Management

ICM Service	Description
Outcomes tracking and analysis	Constant patient monitoring by the entire Kaiser Permanente care team optimizes outcomes for both individuals and populations. Doctors, specialists, nurses, health educators, and lab techs work together, sharing information, protocols, and best practices for better outcomes. The care team is connected by and has access to a single electronic health record, reducing or eliminating care and information gaps. Third-party disease management programs are disconnected from care providers and clinical data—they're usually working from call centers and refer to claims data only.
Employer reporting and wellness program consultation	Partnership in Health chronic condition reports collect aggregate clinical data, track HEDIS measures and health outcomes, and reveal the prevalence and cost of certain chronic conditions. Recommendations for workforce health improvement—including wellness programs—are provided based on the results. This level of clinical data reporting isn't possible with fee-for-service, fragmented care models.

4299

Chronic Conditions Management

ICM Service	Description
Member outreach and inreach	Includes patient outreach (by phone, mail, and other collateral) and inreach (via electronic alerts within their electronic health record and face-to-face prompts that occur during patient visits). Proven to increase member adherence to care protocols such as screenings, immunizations, and scheduled tests.
Patient self-care tools and education for chronic conditions	Includes health education classes, online tools and calculators, videos, and brochures that address chronic conditions such as diabetes or asthma.
Digital coaching for chronic conditions	Customized and interactive online programs help members manage their chronic conditions with relevant information around diet, exercise, medication, stress management, and more. Member self-reported data is used to generate aggregate reports on program use and effectiveness.

4300

Pharmacy Management

ICM Service	Description
Discount/rebate negotiation with manufacturers	We leverage our organizational size to negotiate prescription drug prices, helping reduce costs.
Automated refills by phone or online; no additional costs for mail order on all prescriptions; prescription refill email reminders; refill status online; online access to pharmacists	Members can conveniently order prescription refills online 24 hours a day, 7 days a week and have them delivered to their homes at no additional cost—saving time away from work. Refill email reminders help increase pharmacy adherence, improving outcomes. Members can also email questions to a Kaiser Permanente pharmacist anytime.
Formulary development	Our practicing physicians and pharmacists work together to build an evidence-based formulary. This physician-led process results in greater formulary adherence. Also includes research teams that track new FDA drug approvals and analyze studies and comparative prices of existing therapies. We also study member drug outcomes using Kaiser Permanente HealthConnect®—information is shared quickly and efficiently across the organization. And unlike in the fragmented fee-for-service world, pharmaceutical reps are restricted from Kaiser Permanente campuses.

4301

Pharmacy Management

ICM Service	Description
Physician education	Includes the automatic dissemination of formulary guidelines, medication best practices, safety prompts, and alerts to physicians via our electronic health record system. Also includes dedicated pharmacy educators who work to develop site-specific physician medication education programs.
Patient counseling and education	Includes face-to-face consults and printed instructions for all new and changed prescriptions for members—improving adherence.
Anticoagulation clinic (use of warfarin, also known by brand-name Coumadin)	Refers to clinics specializing in blood thinner treatment for clotting disorders. Physicians refer high-risk patients to pharmacist-led anticoagulation teams to manage status within a narrow therapeutic window. Physician continues to work closely with the pharmacist, supervising and collecting quality data. Established programwide. Our "center of excellence" approach results in high patient volume (700 patients annually vs. 3 to 10 for private practice), which leads to increased expertise and better outcomes (patient risk mortality is 1% at Kaiser Permanente versus the published results of 8 to 12% outside of Kaiser Permanente).

4302

Online Personal Health Management

ICM Service	Description
Clinically populated personal health record	Member personal health records draw clinical health information in real time from our electronic medical record system, KP HealthConnect. Other health plans may offer personal health records, but they draw information from claims data or rely on members to self-report information. Our clinically based records are populated, shared, and accessed by care team members. Members can also suggest updates to their personal health record information.
After-visit summary	After-visit summaries include treatment plans, physician notes, vitals, and more. Members can review their summaries online anytime.
Rapid posting of lab results	Members can view select lab results online—sometimes the same day the test was taken. Results also show information on why the test was taken and how to interpret results. This feature saves members from having to take time off work to make an office visit or a phone call.
Schedule/manage appointments	Members can request and review routine appointments online, at their convenience, saving a phone call.

4303

Online Personal Health Management

ICM Service	Description
View allergy treatment/immunization schedules	Members can review their or their children's allergies and immunization histories online instead of relying on paper records. This convenient, time-saving feature especially helps parents of school-age children who must frequently provide proof of immunization status.
View status for recommended preventive screenings	Members can access a list of their recommended or scheduled health screenings. Members also receive electronic health prompts for overdue tests and screenings, increasing adherence and improving health.

4304

Wellness Information and Coaching

ICM Service	Description
Web-based health education content and tools for wellness	Includes **kp.org** clinical content available to members and nonmembers—encyclopedias, videos, virtual tours of our maternity departments, podcasts, featured topics, tools, and calculators target lifestyle-specific risk behaviors such as smoking.
Targeted health and wellness mailings and reminders	Includes mail and phone outreach for preventive care for nonchronic conditions (flu shots, vaccinations, immunizations, health screenings) to help keep members healthy. Outreach comes from the care providers, not the health plan, increasing the importance of the mailing from the member's perspective.
Health education classes and support groups	Covers a wide array of health education classes and peer-support groups conveniently located at Kaiser Permanente facilities. Classes promote preventive care, encourage fitness and nutrition, and support treatment plans.
Health risk assessment tools integrated with care management services	Includes total health assessments, which give members a detailed overview of their lifestyle and health risks and assess their readiness to change. Unlike with other health plans, the results can be added to members' electronic medical record for discussion with their physician.

4305

Wellness Information and Coaching

ICM Service	Description
Newsletter and other health information	Includes our *Partners in Health* member newsletter and health topic–specific communications (e.g., senior health, maternity) in a variety of languages to support culturally competent care.
Telephonic health coaching	One-on-one personal coaching motivates members to establish and meet health goals such as smoking cessation, weight loss, or improved nutrition. Coaches have access to member health records for a total health approach.
Digital coaching for wellness	Interactive and customized, these online programs help members improve their health by addressing a variety of lifestyle risk behaviors. Member self-reported data is used to generate aggregate reports on program use and effectiveness.
Other programs (walking programs, discounted fitness/gym rates)	Includes Thrive Across America℠ fitness program, gym/fitness club discounts, and complementary care programs that support total health.

4306

Telephonic Clinical Advice

ICM Service	Description
Integrated nurse advice and appointment system	Our 24/7 nurse advice line is staffed by Kaiser Permanente nurses with access to member medical records and an available physician to handle more serious calls. With access to clinical data, nurses can triage members more effectively and make appointments when appropriate. They also help members save money by avoiding trips to urgent and emergency care for nonurgent conditions. Other health plans hire nurses with access to claims data and little or no connection to the clinical care experience.

4307

External Provider Network Management

ICM Service	Description
External provider network building and maintenance	Includes identifying, contracting with, and reviewing external provider networks. The networks are reviewed, approved, and managed by Permanente physician groups in partnership with our health plan to provide clinical oversight. Most other health plan networks are reviewed, approved, and managed by health plan administrators only.
Competitive network discounts	Network rates are negotiated, leveraging volume to achieve competitive discounts where applicable.
Access to discounted affinity networks for complementary medical care	Special rates are negotiated for acupuncture, massage, and chiropractic care.
Arrangements with out-of-area providers	Arrange access and negotiate prices with out-of-area providers that provide care to members on an ad hoc basis (in cases like travel emergencies).
Claims repricing	Includes the processing and negotiation of claims from outside providers.
Access to "center of excellence" networks for transplants and other specialized services	Includes identifying, contracting with, and integrating operations with care centers to effectively support patients in need of highly specialized care.

4308

Medical Case Management

ICM Service	Description
Evidence-based clinical guidelines	Includes development, vetting, and electronic dissemination of clinical best practices that drive quality and cost-efficiencies. Also includes support for and leveraging of academic research resources and results from our clinical research departments and Care Management Institute. As a result, we can go from cutting-edge knowledge to implementation in just one year—outside of Kaiser Permanente, it can take 17 years for best practices to become standard.
Preadmission review	Includes review of patient medical record prior to hospital admission (labs, imaging, prescriptions, and more). Ensures admission is for the right reasons. A single technology platform—KP HealthConnect—makes the process efficient, seamless, and consistent. Outside of Kaiser Permanente, hospital care is often disconnected from outpatient care, resulting in a lack of care continuity, redundancy in testing/procedures, and patient inconvenience.
Concurrent review	Includes in-hospital physician care provided by specialists like hospitalists and intensivists.
Discharge planning	Includes outpatient visits, instructions, and ordering of post-visit medications.
Hospital and skilled nursing transition programs	Programs staffed by Kaiser Permanente physicians and nurse practitioners help ensure speedy and appropriate transitioning of patients to the right level of care.

Medical Case Management

ICM Service	Description
Case management services (high-intensity/complex case management)	Includes outreach, integration with other care management programs/behavioral health programs, and patient identification triggers and treatment plans for high-need, high-cost patients. Optimizes care and efficiencies. Outside of Kaiser Permanente, case coordination is inconsistent—responsibility can be on the primary care physician, hospital, patient, or a health plan case manager who doesn't have ready access to the full medical record.
Transplant cases	Includes identification, transfer, and management of transplant cases. Also includes our internal transplant review board and all pre- and post-care provided by Kaiser Permanente physicians.
Integrated behavioral health/medical case management	Includes depression screening for high-risk members (those with diabetes, coronary artery disease, or congestive heart failure, or pregnant and postpartum women) who complete a total health assessment, and for members with prior depression or suicidal thoughts. Also includes coordination of inpatient transfers to the appropriate case worker or psychiatrist if more serious. Kaiser Permanente behaviorists and social workers are integrated within our care delivery system, working closely with primary care and medical case management teams to help ensure timely, immediate, continuous care, improved outcomes, and lower costs.

4310

Medical Case Management

ICM Service	Description
Quality assurance and management	Includes internal utilization management and physician peer review to drive better, more cost-efficient outcomes. Physician peer review includes system reviews, which address systems issues and help doctors practice better medicine. Outside of Kaiser Permanente, physician peer review is inconsistent and not as widespread, if it exists at all.
Systems support, including case tracking	Includes non-chronic condition (such as maternity, cancer, and allergy care) and orthopedic implant health registries used to identify care and medication gaps. Technology increases safety and interaction control and enables an overall view of the member's health.
Referral management	Includes Permanente Medical Group prospective review and approval of care outside the Kaiser Permanente network.
Emergency prospective review program (Emergency Department repatriation)	Kaiser Permanente Emergency Department physicians coordinate with outside Emergency Departments to provide critical and potentially lifesaving member health information. This helps ensure the safe and timely return of the member to Kaiser Permanente facilities, optimizing care and reducing costs. Outside of Kaiser Permanente, patient medical histories (such as medications and previous tests) are often unavailable to the treating physicians.

Medical Case Management

ICM Service	Description
Palliative care	Kaiser Permanente works to support patients and their families through a team-based approach that creates the best access to people who are specially trained to provide care in the last stages of life. Outside of Kaiser Permanente, it's very difficult to create a consistent level of support. Some health plans reimburse for services, but when there are no community-based services, offer little real benefit to members.

4312

Board of Supervisors

4313

Approval of Health Service System Rates and Benefits for Plan Year 2014

July 17, 2013

Recent Discussions With Kaiser

- HSS has been in constant negotiations with Kaiser since the last Budget and Finance Committee hearing on July 10, 2013.
- Kaiser cannot reduce the premium rate for 2014 because it is based on a standard methodology that is consistent across all large public and private employers.
- Kaiser can provide support outside of the current agreement. Negotiations over the past week have resulted in additional commitments by Kaiser on wellness, transparency and accountability.
- Representatives from Kaiser are here to respond to questions and detail what they can offer to the City & County of San Francisco for 2014 and 2015.

4314

Health Service Board and HSS Position

- Health Service Board directed HSS to immediately begin negotiations with Kaiser for 2015.
- During 2014 negotiations, the Health Service Board and HSS expressed concern about Kaiser shifting costs into a non-service category called Integrated Care Management (ICM).
- The Health Service Board and HSS hoped to see a lower overall rate increase, but do not consider a 3.48% Kaiser premium increase to be unreasonable for a fully insured plan.
- Kaiser remains the lowest cost plan for employers, with the lowest cost contribution for employee and retiree members.
- Kaiser rates were approved by the Health Service Board, in the best interest of the four employers served by HSS and all HSS members.

Operational Implications of Option B

The timeline for returning a new package to the Board of Supervisors:

July 31-August 2	Request new rate offers from Blue Shield and Physician Groups in 3 days
August 5-11	Prepare new actuarial report on two plan model
August 11-14	Post notice of Health Service Board meeting
August 15	Health Service Board meeting
August 19-20	Board of Supervisors Budget packet
August 28	Board of Supervisors Budget Committee hearing
September 3 and 10	Full Board of Supervisors hearings

4316

Financial Implications of Option B

- All medical services will become self-insured with increased financial risk to the Health Service Trust and employers.
- Elimination of Kaiser may affect hospital and medical group pricing and contracts moving forward.
- Competition is one of the most effective mechanisms for containing benefit costs
- Recalculation of City budget and GASB liability

Legal Implications of Option B

- If Open Enrollment does not take place as scheduled, or if member contribution rates are not available, litigation may ensue.
- Employers and HSS will be subject to federal fines.

4318

LOCAL 1021
SEIU
Stronger Together

July 16, 2013

San Francisco Board of Supervisors
1 Dr. Carlton B. Goodlett Place
City Hall, Room 244
San Francisco, CA 94102-4689

Subject: 2014 Kaiser Rates

SEIU Local 1021 appreciates the scrutiny that Kaiser's proposed rate increase has received from the San Francisco Health Services System ("HSS") and the Budget and Finance Committee of the Board of Supervisors. We call on the Board of Supervisors to continue to bring pressure on Kaiser to ensure a fair rate and increased transparency.

Kaiser's 2014 proposed premium includes a 5.25% increase, or an additional $15 million, even though members are healthier and using fewer services. For months, Kaiser has refused to justify the increase, leading HSS to analyze Kaiser renewal pricing, utilization, and costs over the past seven years.

HSS found that we paid $87 million more to Kaiser than it cost Kaiser to provide care for HSS members between 2010 and 2012. This amounts to a 13% profit margin, far in excess of Blue Shield's 2% profit pledge.

Here are the undisputed facts:

- HSS members' utilization of inpatient, outpatient, and pharmacy services at Kaiser has either slowed or decreased, but the unit cost charged for services has increased sharply from 2007 to 2014. For example, while inpatient utilization declined by 36% over seven years, Per Member Per Month inpatient costs increased by 19%.

- Kaiser's 2014 premium includes additional fees for unreported and unverifiable "Integrated Care Management" (ICM) and "Other Medical Services" (OMS). HSS is therefore unable to validate the services associated with fees that account for 14% of the 2014 premium.

- In one year, ICM and OMS fees rose from $49 to $71 (+40%) for employees and from $49 to $106 (+115%) for early retirees. The increase in these fees alone adds $14.9 million to the 2014 premium. In total, these fees for unreported services are $39.2 million of the 2014 premium. Kaiser admits these are new charges, not new services.

2300 Boynton Avenue, Suite 200 ▪ Fairfield, CA 94533 ▪ 707-422-9464 ▪ Fax 707-422-5107
Service Employees International Union CtW, CLC ▪ www.seiu1021.org

LOCAL 1021
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Roxanne Sanchez
President

Crawford Johnson
Region A

Tom Popenuck
Region B

Gary Jimenez
Region C

Larry Bradshaw
Region D

Marcus Williams
Region E

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Doug Marr Julie Meyers Peggy La Rossa Paul Little Nadeen Roach

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From: Board of Supervisors
To: BOS-Supervisors; Young, Victor
Subject: File ~~130481~~ health plans

Files # 130653 + 130654

From: Madeline Ritchie [mailto:mritchie03@gmail.com]
Sent: Friday, July 12, 2013 11:58 AM
To: Board of Supervisors
Subject: health plans

Clerk of Board of Supervisors:

I would like to request that you send my message to all Supervisors.

The recent article in the Chronicle indicated that two Supervisors were questioning the continuation of Kaiser Health plan for employees both active and retired.
PLEASE do not let this happen.

Notably, retired persons have chronic and for some,life threatening illnesses. For them to seek a new Health Plan and new Doctors is unfair.
There are no justifiable reasons to stop Kaiser has a health plan . Two Superviosrs felt that Kaiser did not explain fully the reason for their proposed increase in rates.

Please keep in mind that other health plans have increased rates and we have kept them on board.
Kaiser has been a leader in providing quality health care.

If this is not resolved by July 31, 2013 then we may lose Kaiser as a Health Plan for SF City workers.

Please find another process where there will be adequate time for all to know the issues and for more input.

Thank you for your considerations.
Madeline Ritchie, CCSF,Retiree

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To: BOS-Supervisors; Young, Victor
Subject: File ~~130481~~ health plans

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- Kaiser's self-reported profits are $2 billion annually over the past four years. These profits are calculated after accounting for the costs of community benefits, facilities expansion, and infrastructure upgrades.

- HSS would have saved $84 million in active employee premiums between 2007 and 2012 if Kaiser profits were capped at 4 percent and ICM and OMs costs capped at 10% of the total premium.

Health care is a seller's market. We cannot do without health care services even if we can't afford them. While Kaiser has thrived under the cover of "proprietary," the City has had to cut back on services in a recession caused by Wall Street profiteering. City employees have given up wage increases and are paying more and more their benefits.

Kaiser's refusal to negotiate and to disclose information repeatedly requested by HSS is intolerable. If Kaiser can make a 13% profit from doing business with HSS, shield 29% of the 2014 premium from HSS scrutiny, increase fees in response to declining utilization, then what's to stop other commercial health plans and providers from adopting these same practices?

HSS is to be commended for putting the facts on the table for public consideration and for aggressive and successful efforts over the past four years to improve the quality, efficiency, and affordability of health care services for city beneficiaries.

Kaiser, however, has remained intransigent on its 2014 premium demand, adopting a "take it or leave it position." We believe the Board of Supervisors should engage Kaiser and the Health Service System to ensure:

1. Kaiser rebates $11 million of the 2014 premium million to HSS;
2. Kaiser fully reports the utilization and cost of medical services and discloses the trend data and other information that it uses internally to project its costs
3. SEIU has a seat at the table in future HSS negotiations with Kaiser and other contracted health plans;
4. Kaiser withdraws its opposition to SB 746 establishing transparency.

Thank you very much for your attention to this matter.

Young, Victor

rom: Board of Supervisors
Sent: Tuesday, July 16, 2013 10:09 AM
To: Young, Victor
Subject: SEIU Local 1021 on Kaiser Rate
Attachments: SEIU 1021 on Kaiser Rate.pdf

From: Chris Daly [mailto:chris.daly@seiu1021.org]
Sent: Tuesday, July 16, 2013 10:06 AM
To: Board of Supervisors; Chiu, David
Cc: Mar, Eric (BOS); Farrell, Mark; Tang, Katy; Breed, London; Kim, Jane; Yee, Norman (BOS); Wiener, Scott; Campos, David; Cohen, Malia; Avalos, John
Subject: SEIU Local 1021 on Kaiser Rate

July 16, 2013

To: San Francisco Board of Supervisors
Re: 2014 Kaiser Rates

SEIU Local 1021 appreciates the scrutiny that Kaiser's proposed rate increase has received from the San Francisco Health Services System ("HSS") and the Budget and Finance Committee of the Board of Supervisors. We call on the Board of Supervisors to continue to bring pressure on Kaiser to ensure a fair rate and increased transparency.

Kaiser's 2014 proposed premium includes a 5.25% increase, or an additional $15 million, even though members are healthier and using fewer services. For months, Kaiser has refused to justify the increase, leading HSS to analyze Kaiser renewal pricing, utilization, and costs over the past seven years.

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- The 2014 premium includes $41.5 million to cover Kaiser's "projected costs" based on trend data and other information that Kaiser calls "proprietary" and refuses to disclose. Kaiser reports that the annual trend applied to HSS renewals, ranging from 6.21% to 12.67% over the past seven years, is based on desired revenue targets.

Young, Victor

From: Raul.Monares@kp.org
Sent: Wednesday, July 17, 2013 1:43 PM
To: Sass, Gregg; Young, Victor
Cc: Cynthia.Striegel@nsmtp.kp.org; Kathy.J.Rymer@nsmtp.kp.org
Subject: Kaiser Permanente Presentation to the BoS BFSC 7-17-13
Attachments: KP Presentation to the BoS BFSC 07.17.13.pdf

Follow Up Flag: Follow up
Flag Status: Flagged

Hi, Gregg.

As you requested, attached is a copy of the presentation that Cynthia Striegel, VP, Strategic Accounts and Peter Andrade, Sr. VP, Sales and Account Management delivered to the Board of Supervisors - Budget and Finance Sub Committee today.

By copy of this email I'm also delivering a copy to Victor.

Thank you very much.

Raul Monares
Director, Oakland & Cupertino

Kaiser Permanente
Strategic Accounts
1800 Harrison Street, 9th Floor
Oakland, CA 94612

510.625.4715 (office)
8.428.4715 (tie-line)
510.292.8586 (mobile phone)
For assistance or scheduling please contact Tanya LaMere at 510.625.4428 or tanya.l.lamere@kp.org

Young, Victor

From: Jewlia Eisenberg [jewlia@earthlink.net]
Sent: Wednesday, July 17, 2013 9:27 AM
To: Avalos, John
Cc: Farrell, Mark; Mar, Eric (DPH); Young, Victor; Stefani, Catherine; Nicolas.Pagoulatos@sfgov.org; Pollock, Jeremy
Subject: Item 12 on Today's Agenda: Support for Continued Negotiations With Kaiser

Follow Up Flag: Flag for follow up
Flag Status: Flagged

Dear Board of Supervisors,

My name is Jewlia Eisenberg; I am writing in reference to item 12 on today's agenda. I am a musician who has worked in SF for 15 years and the wife of city employee AnMarie Rodgers.

I have a rare and dangerous immune system condition for which I get life-saving treatment from Kaiser. My doctor at SF Kaiser has been recognized on a national level by top immunologists from Stanford to the National Institute for Health in DC for his combination of innovation and long experience. Stellar doctors like him provide an exceptional quality of care. The Kaiser system--where entire treatment teams from multiple departments are deployed, meet regularly and are in excellent contact with patents and families--is an unusually effective system for helping sick people get better and helping well people stay that way.

I absolutely agree that Kaiser should disclose all reasoning behind their fee increase. But due to the huge potential impact for the many City workers and families that are served so well by Kaiser, I urge you to continue negotiations. Please try and keep working with Kaiser.

Thank you,
Jewlia Eisenberg
jewlia@charminghostess.com
www.charminghostess.com

KAISER PERMANENTE®

Health Service System

City and County of San Francisco

2014 Renewal

KAISER PERMANENTE®

Strategic Accounts
1800 Harrison Street, 9th Floor
Oakland, CA 94612

April 15, 2014

Mr. Anil Kochhar, ASA, MAAA
AON Hewitt Consulting Health & Benefits
199 Fremont Street, Suite 1500
San Francisco, CA 94105

Re: City and County of San Francisco – Health Service System
January 1, 2014 – December 31, 2014
Kaiser Permanente Northern California - 888
Kaiser Permanente Southern California - 231003

Dear Mr. Kochhar,

Thank you for the opportunity to provide renewal information for the health plans with Kaiser Permanente in California. We value our long-term relationship with the City and County of San Francisco – Health Service System and look forward to continuing our partnership into the future.

As a nonprofit, we are not driven to make business decisions that affect share value at the expense of good medicine.

We have the industry's most effective wellness and disease management programs. For example, our cardiac care management program is so effective that risk of death from heart disease is 30% lower for Kaiser Permanente Northern California members than for nonmembers when matched for age and gender.

Sound management practices, cost-effective medicine, and innovative thinking: These are the reasons we have received top rankings from the nation's leading consumer review publication and the National Committee for Quality Assurance (NCQA).

This letter and accompanying documents provide information regarding the 2014 renewal rate action.

Kaiser Permanente reserves the right to make any change in these rates and benefits due to changes in state or federal legislation, regulatory action, and conditions of offering relative to the contribution strategy.

Rating documents are enclosed, along with the corresponding utilization reports. In addition to the standard assumptions, please note the following underwriting caveats:

- Benefit parity with the other carriers would be necessary for Kaiser Permanente to change its benefits

- Please refer to the Rate Assumptions and Requirements under Proposal Assumptions, Item # 7.

Please note, decisions for any benefit changes will need to be communicated to my office, in writing, at least 30 days prior to the renewal date; otherwise, benefit changes will become effective the following month after the renewal date.

The overall rate increase for the Health Service System – City and County of San Francisco from the current 2013 rate is + 3.48%, plus Health Care Reform fee/taxes of 1.77%. The total renewal increase is 5.25%.

Pricing summary:

Groups with more than 1,000 plan members are fully credible and, therefore, fully experience rated. Annual claims for any individual exceeding the pooling point of $550K are excluded from the renewal calculation. Pooled claims include all medical and prescription drug claims. Our pricing model includes a rate-capping feature to reduce the volatility of renewal rates from one year to the next.

The following is a summary of the significant renewal drivers:

- Active Claims went up 5.5% over last year
- ACA taxes added approximately one and three quarter points to the increase
- Kaiser Permanente's lower trend factor for 2014 resulted in a 1.5% decrease to this renewal
- Early Retiree claims went up by 8.7%
  - The lower trend and decrease in their IBNR offsets the higher claims and ACA taxes

Renewal rate information for Actives is as follows:

	Current Rates 2013	Renewal Rates 2014	Rate Action Blended
Subscriber only	$531.19	$559.07	5.25%
Subscriber + 1 dependent	$1,062.38	$1,118.14	5.25%
Subscriber + 2 or more dependents	$1,503.27	$1,582.17	5.25%

Early Retirees (Non- Medicare):

	Current Rates 2013	Renewal Rates 2014	Rate Action Blended
Subscriber only	$1,072.27	$1,128.63	5.25%
Subscriber + 1 dependent	$1,603.46	$1,687.70	5.25%
Subscriber + 2 or more dependents	$2,044.35	$2,151.73	5.25%

Retirees - Senior Advantage Plan - with Medicare Part D:

	Current Rates 2013	Renewal Rates 2014	Rate Action Blended
Subscriber only	$329.60	TBD	TBD
Subscriber + 1 dependent	$659.20	TBD	TBD
Subscriber + 2 or more dependents	$988.58	TBD	TBD

As requested, Kaiser Permanente Senior Advantage rates will be released early with an estimated delivery on May 15, 2013. This early release date includes the stipulation the rate will be reconciled during next year's renewal.

As previously discussed, the COST Plan will not be offered in 2014. Any members in this plan will need to be transition to KPSA or another plan offering effective December 31, 2013. We would be glad to work with the administrative staff to support this transition.

Your request for a self-funded quote is currently in process. However, our self-funding rating model is not yet available. We will keep you informed of our progress.

We look forward to meeting with your team and HSS management on April 18, to review this renewal action, to discuss possible benefit options, and strategy moving forward. During this time, we can also further address your request for an explanation on the ICM cost and your benefit plan modifications.

It is our goal to work closely with AonHewitt and with the Health Service System – City and County of San Francisco to ensure we address any questions and/or concerns.

Best regards,

Kathy J. Rymer

Kathy J. Rymer
Executive Account Manager
Kaiser Foundation Health Plan, Inc.
Strategic Accounts
1800 Harrison Street, 9th Floor
Oakland, CA 94612
510-625-2965 Office
510-625-3278 Fax

Kathy.J.Rymer@kp.org
CA License is OB9237

Enclosures:
2014 renewal materials, including the preliminary summary of benefit changes
Customer report packet, including executive summary, rate buildup, rate and benefit summary, and assumptions pages for Kaiser Permanente California Regions

RATE PROPOSAL

HEALTH SERVICE SYSTEM (CITY AND COUNTY OF SF)

Effective from 01/01/2014 through 12/31/2014

Region(s)	Group(s)	Subgroup(s)
Northern California	888	0000, 4900, 7000

Table of Contents

Executive Summary

Group Name: HEALTH SERVICE SYSTEM (CITY AND COUNTY OF SF)
Group Number(s): 888
Subgroup(s): 0000,4900,7000

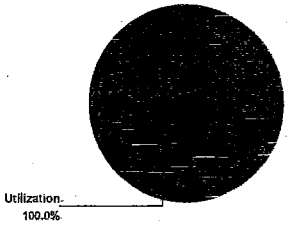
Region: Northern California
Contract Period: 01/01/2014 - 12/31/2014

	Jan11 - Dec11	Jan12 - Dec12
Average Members*:	37,307	39,043

Rates**

	Current Rates	Change %	Proposed Rates
TRADITIONAL PLAN: **$20 OV; $100/ADMISSION IP; $100 ER; OPT; CHIRO; HEAR;**			
Subscriber only	$531.19	5.25%	$559.07
Subscriber and 1 dependent	1,062.38	5.25%	1,118.14
Subscriber and 2 or more dependents	1,503.27	5.25%	1,582.17

Credibility



Claims Summary $PMPM*

TRADITIONAL PLAN:

Major Service Category	Jan11 - Dec11	Change	Jan12 - Dec12
Inpatient	$140.40	(3.0)%	$136.18
Outpatient	127.59	(1.5)%	125.68
Pharmacy	36.30	8.5%	39.40
Other	56.85	40.0%	79.57
Total Claims Summary $PMPM	**$361.15**	**5.5%**	**$380.85**

* Includes Actives and /or pre 65 Retirees only.
**Benefit plan descriptions are summarized, please see Rate and Benefit Summary for full descriptions.

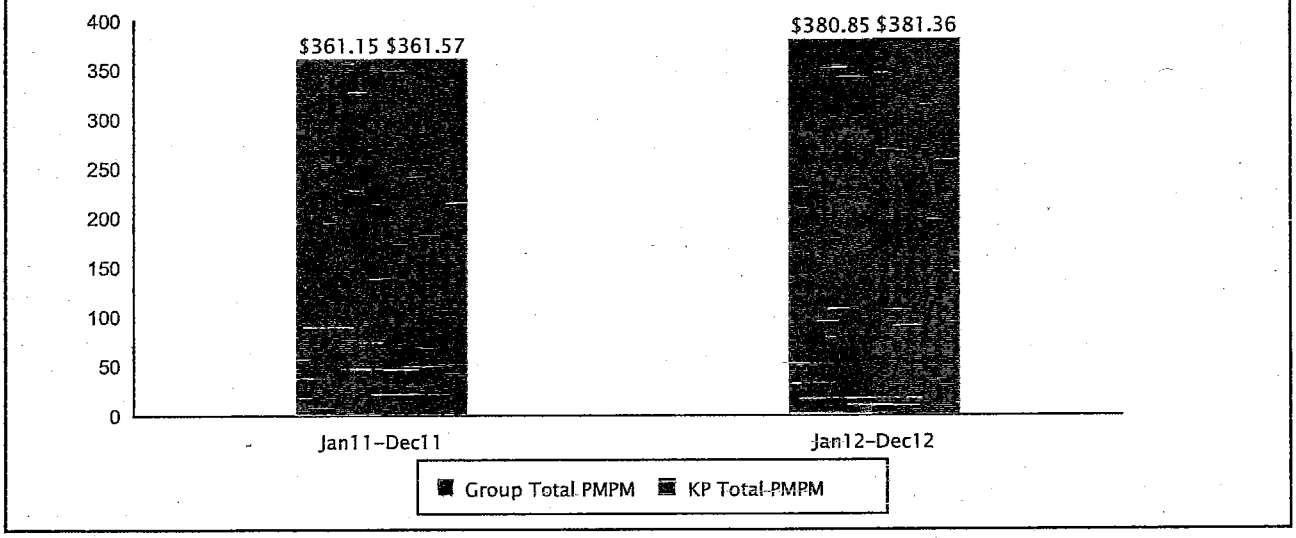
Total – $ PMPM

Group Name: HEALTH SERVICE SYSTEM (CITY AND COUNTY OF SF)
Group Number(s): 888
Subgroup(s): 0000,4900,7000

Region: Northern California
Contract Period: 01/01/2014 – 12/31/2014

	Jan11 – Dec11	Jan12 – Dec12
Average Members*:	37,307	39,043

Total $ PMPM



Total $ PMPM *

Service Category	Jan11 – Dec11	Change	Jan12 – Dec12
Inpatient	$140.40	(3.0)%	$136.18
Outpatient	127.59	(1.5)%	125.68
Pharmacy	36.30	8.5%	39.40
Other	56.85	40.0%	79.57
Total $ PMPM	**$361.15**	**5.5%**	**$380.85**
Group to Health Plan Ratio	99.9%	0.0%	99.9%

* Includes Actives and/or pre 65 Retirees only.

Rate Buildup

Group Name: HEALTH SERVICE SYSTEM (CITY AND COUNTY OF SF)
Group Number(s): 888
Subgroup(s): 0000,4900,7000

Product Type: HMO

Region: Northern California
Contract Period: 01/01/2014 - 12/31/2014
Report Period: Jan 2012 through Dec 2012

	Jan11 - Dec11	Jan12-Dec12
Average Members:	37,307	39,043

Rating Month: February 2013
Rating Members: 40,516

	Medical Calculation		Weight	Factor	Total$	PMPM$
A	**Projected Claims Calculation**					
A1	Paid Claims				$178,432,064	$380.845
A2	- Pooling Credit	Pooling Point:$550,000			(2,566,678)	(5.478)
A3	+ Pooling Charge				3,251,501	6.940
A4	Claims Net of Pooling				$179,116,887	$382.307
A5	X Incurred Claims Adjustment			1.01056		
A6	X Demographic Change			1.00009		
A7	X Historical Benefit Change			0.997740		
A8	Adjusted Claims					$385.506
A9	X Trend Factor	Annual Trend: 6.21%		1.12809		
A10	Claims based PMPM	24.0 Months Midpoint to Midpoint				$434.886
A11	Credibility		100%			

	Total Rate Calculation	Factor	Mo. Prem.	PMPM$
D	**Total Rate Calculation**			
D1	Blended Rate		$17,619,841	$434.886
D2	X Future Benefit Change	1.000000		
D3	Adjusted PMPM		$17,619,841	$434.886
D4	+ Retention		1,011,685	24.970
D5	+ Other Benefits		72,929	1.800
D6	+ Group Specific Charge		0	0.000
D7	+ Late Payment Charge		0	0.000
D8	+ Federal Health Insurer Fee		123,817	3.056
D9	+ Federal PCORI Fee/Transitional Reinsurance Program Contribution		219,597	5.420
D10	+ Premium Tax		0	0.000
D11	+ Commission		0	0.000
D12	**PMPM Premium Requirement**		**$19,047,868**	**$470.132**
E1	In-Force Rate		$18,202,380	$449.264
E2	**Quoted Rate PMPM before Underwriter Adjustment**	**4.65%**	**19,047,868**	**470.132**
E3	X Underwriter Adjustment	1.00348		
E4	**Quoted Rate PMPM after Underwriter Adjustment**	**5.01%**	**19,114,152**	**471.768**

Membership – Age and Gender Demographics

Group Name: HEALTH SERVICE SYSTEM (CITY AND COUNTY OF SF)
Group Number(s): 888
Subgroup(s): 0000,4900,7000

Region: Northern California
Contract Period: 01/01/2014-12/31/2014

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Members*

Age	Average Jan11-Dec11 Male	Female	Total	Percent	Average Jan12-Dec12 Male	Female	Total	Percent	Current as of Feb13 Male	Female	Total	Percent
0-0	160	151	311	0.8%	176	171	347	0.9%	185	195	380	0.9%
1-4	798	749	1,546	4.1%	813	762	1,575	4.0%	836	804	1,640	4.0%
5-9	1,129	1,137	2,266	6.1%	1,200	1,159	2,359	6.0%	1,261	1,210	2,471	6.1%
10-14	1,279	1,268	2,547	6.8%	1,318	1,326	2,644	6.8%	1,372	1,386	2,758	6.8%
15-19	1,514	1,450	2,964	7.9%	1,575	1,449	3,024	7.7%	1,633	1,457	3,090	7.6%
20-24	1,491	1,488	2,978	8.0%	1,552	1,586	3,138	8.0%	1,589	1,644	3,233	8.0%
25-29	652	919	1,571	4.2%	812	1,103	1,915	4.9%	868	1,161	2,029	5.0%
30-34	943	1,361	2,304	6.2%	1,040	1,488	2,527	6.5%	1,149	1,577	2,726	6.7%
35-39	1,254	1,500	2,755	7.4%	1,286	1,627	2,912	7.5%	1,281	1,714	2,995	7.4%
40-44	1,694	1,850	3,544	9.5%	1,752	1,939	3,691	9.5%	1,818	2,006	3,824	9.4%
45-49	1,850	1,990	3,840	10.3%	1,904	2,040	3,944	10.1%	1,942	2,071	4,013	9.9%
50-54	2,011	2,019	4,030	10.8%	2,019	2,054	4,073	10.4%	2,047	2,123	4,170	10.3%
55-59	1,746	1,711	3,457	9.3%	1,764	1,731	3,495	9.0%	1,847	1,758	3,605	8.9%
60-64	1,187	1,089	2,276	6.1%	1,258	1,139	2,397	6.1%	1,295	1,218	2,513	6.2%
65-69	367	282	650	1.7%	410	317	728	1.9%	448	333	781	1.9%
70-74	130	76	207	0.6%	131	79	210	0.5%	137	84	221	0.5%
75-79	32	16	48	0.1%	32	19	50	0.1%	36	20	56	0.1%
80-84	9	3	12	0.0%	7	4	11	0.0%	5	5	10	0.0%
85+	1	2	3	0.0%	1	0	2	0.0%	1	0	1	0.0%
Total Members	**18,246**	**19,061**	**37,307**	**100.0%**	**19,049**	**19,994**	**39,043**	**100.0%**	**19,750**	**20,766**	**40,516**	**100.0%**
Percentage	48.9%	51.1%			48.8%	51.2%			48.7%	51.3%		

Health Plan Average Age:	33.8	34.6	34.2		33.8	34.6	34.2		33.8	34.6	34.2	
Group Average Age:	35.7	35.3	35.5		35.5	35.2	35.4		35.4	35.2	35.3	
Average Contract Size:			2.11				2.12				2.13	
Demographic Factor:**							1.04726				1.04735	%Change 0.0%

Demographic Change: Current Demo Factor 1.04735 / Exp.Pd Demo Factor 1.04726 = 1.00009

* Includes Actives and /or pre 65 Retirees only.

** Each group's Demographic factor is calculated based on its own demographics compared to that of its Market Segment, not based on a comparison with the Health Plan.

Overview of Utilization

Group Name: HEALTH SERVICE SYSTEM (CITY AND COUNTY OF SF)
Region: Northern California

Group Number(s): 888
Contract Period: 01/01/2014 - 12/31/2014

Subgroup(s): 0000,4900,7000

	Jan11 - Dec11	Jan12 - Dec12
Average Members*:	37,307	39,043

Inpatient Days/1000 *

Service Category	Jan11 - Dec11	Change	Jan12 - Dec12
Medical	72.4	(5.5)%	68.4
Surgical	48.3	(8.9)%	44.0
Maternity	23.8	35.7%	32.3
Mental Health	15.2	17.1%	17.8
Substance Abuse	2.9	82.8%	5.3
SNF	29.4	(32.0)%	20.0
Total Inpatient Days/1000	**191.9**	**(2.2)%**	**187.7**

Inpatient Admits/1000 *

Service Category	Jan11 - Dec11	Change	Jan12 - Dec12
Medical	16.6	(4.8)%	15.8
Surgical	12.5	(15.2)%	10.6
Maternity	9.7	18.6%	11.5
Mental Health	2.4	37.5%	3.3
Substance Abuse	0.2	50.0%	0.3
SNF	1.3	(15.4)%	1.1
Total Inpatient Admits/1000	**42.8**	**(0.7)%**	**42.5**

Outpatient Visits/1000 *

Service Category	Jan11 - Dec11	Change	Jan12 - Dec12
Outpatient Visits	4,257.1	0.1%	4,262.9
Emergency Room	163.2	0.8%	164.5
Surgical / Procedures	106.8	2.2%	109.2
Lab	2,986.0	(0.2)%	2,981.4
Radiology	715.5	(1.2)%	707.1
Total Outpatient Visits/1000	**8,228.6**	**0.0%**	**8,225.2**

Pharmacy Scripts PMPY *

Service Category	Jan11 - Dec11	Change	Jan12 - Dec12
Brand /Formulary	0.5	0.0%	0.5
Brand / Non-Formulary	0.2	(50.0)%	0.1
Generic / Formulary	4.8	0.0%	4.8
Generic / Non-Formulary	0.1	0.0%	0.1
Total Pharmacy Scripts PMPY	**5.7**	**(3.5)%**	**5.5**

* Includes actives and /or pre 65 Retirees Only.

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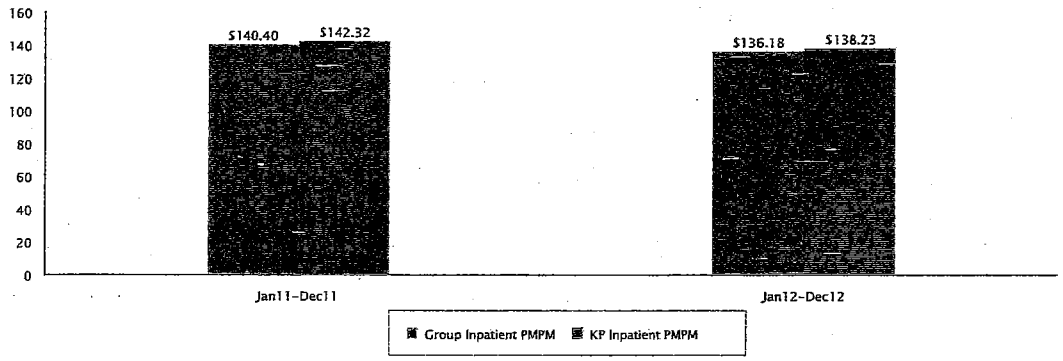
Inpatient – $ PMPM and $/Day

Group Name: HEALTH SERVICE SYSTEM (CITY AND COUNTY OF SF)
Region: Northern California
Group Number(s): 888
Contract Period: 01/01/2014 – 12/31/2014
Subgroup(s): 0000,4900,7000

	Jan11 – Dec11	Jan12 – Dec12
Average Members*:	37,307	39,043

Inpatient $ PMPM



Inpatient $ PMPM *

Service Category	Jan11 – Dec11	Change	Jan12 – Dec12
Medical			
Hospital Medical	$45.62	1.0%	$46.07
Professional Medical	7.61	2.1%	7.77
Surgical			
Hospital Surgical	58.88	(13.1)%	51.14
Professional Surgical	9.80	(19.2)%	7.92
Maternity			
Hospital Maternity	10.08	35.7%	13.68
Professional Maternity	4.38	27.4%	5.58
Mental Health	2.30	18.7%	2.73
Substance Abuse	0.23	34.8%	0.31
SNF	1.50	(34.7)%	0.98
Total Inpatient $ PMPM	**$140.40**	**(3.0)%**	**$136.18**
Group to Health Plan Ratio	98.7%	(0.2)%	98.5%

Inpatient $/Day *

Service Category	Jan11 – Dec11	Change	Jan12 – Dec12
Medical			
Hospital Medical	$7,558.64	6.9%	$8,081.94
Professional Medical	1,261.51	8.0%	1,362.45
Surgical			
Hospital Surgical	14,636.41	(4.7)%	13,954.19
Professional Surgical	2,436.77	(11.3)%	2,161.61
Maternity			
Hospital Maternity	5,087.49	(0.1)%	5,084.35
Professional Maternity	2,211.85	(6.3)%	2,072.46
Mental Health	1,816.03	1.1%	1,836.06
Substance Abuse	957.22	(25.3)%	714.93
SNF	611.05	(3.7)%	588.68
Total Inpatient $/Day	**$8,778.82**	**(0.8)%**	**$8,705.77**

* Includes Actives and /or pre 65 Retirees only.

Inpatient – Days/1000 and ALOS

Group Name: HEALTH SERVICE SYSTEM (CITY AND COUNTY OF SF)
Region: Northern California
Group Number(s): 888
Contract Period: 01/01/2014 – 12/31/2014
Subgroup(s): 0000,4900,7000

	Jan11 – Dec11	Jan12 – Dec12
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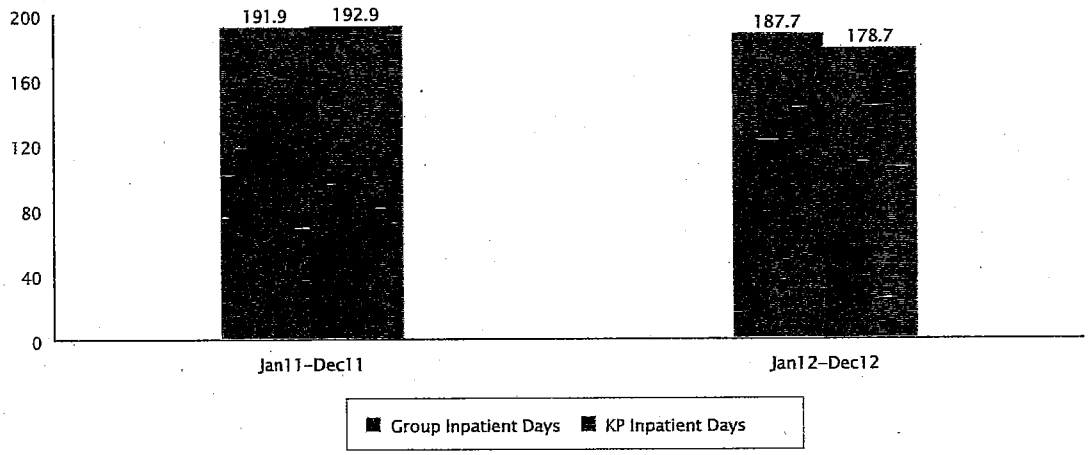
Inpatient Days/1000



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SNF	29.4	(32.0)%	20.0
Total Inpatient Days/1000	**191.9**	**(2.2)%**	**187.7**

Inpatient ALOS *

Service Category	Jan11 – Dec11	Change	Jan12 – Dec12
Medical	4.4	(2.3)%	4.3
Surgical	3.9	5.1%	4.1
Maternity	2.5	12.0%	2.8
Mental Health	6.3	(14.3)%	5.4
Substance Abuse	12.0	55.0%	18.6
SNF	23.3	(18.5)%	19.0
Total Inpatient ALOS	**4.5**	**(2.2)%**	**4.4**

* Includes Actives and /or pre 65 Retirees only.

Inpatient – Admits/1000

Group Name: HEALTH SERVICE SYSTEM (CITY AND COUNTY OF SF)
Region: Northern California
Group Number(s): 888
Contract Period: 01/01/2014 – 12/31/2014
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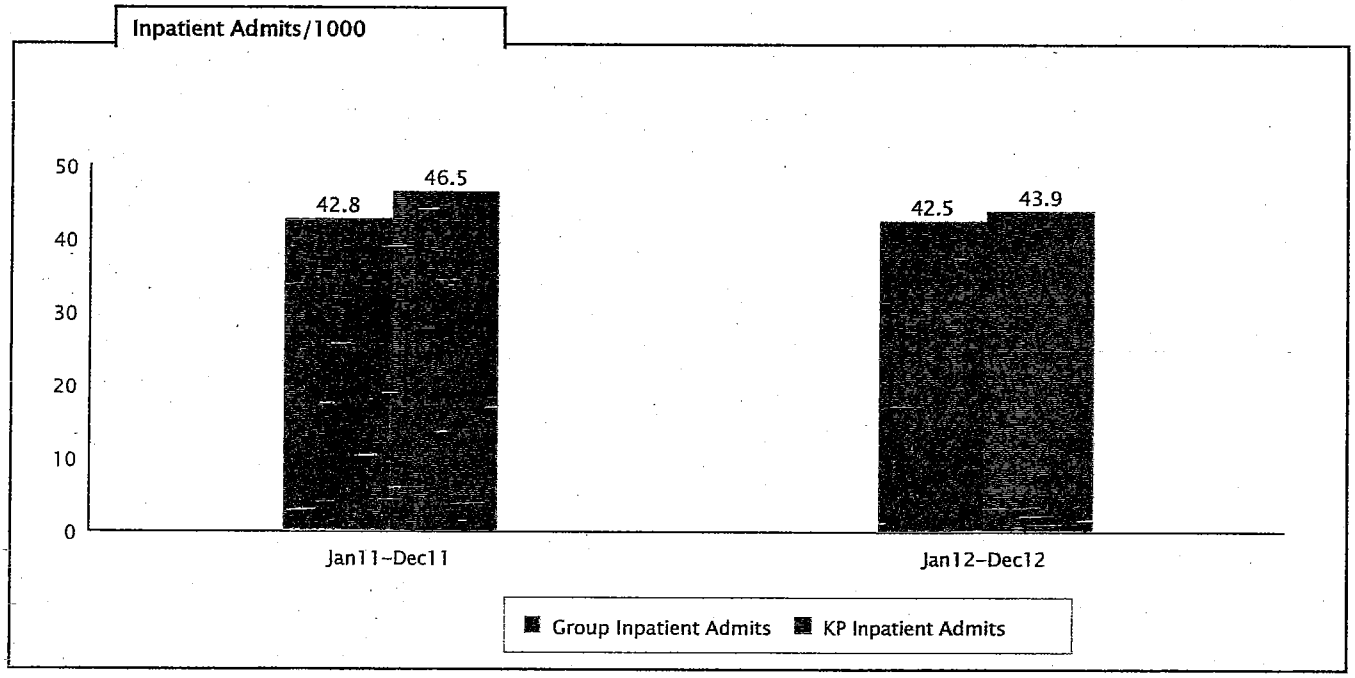

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Mental Health	2.4	37.5%	3.3
Substance Abuse	0.2	50.0%	0.3
SNF	1.3	(15.4)%	1.1
Total Inpatient Admits/1000	**42.8**	**(0.7)%**	**42.5**

* Includes Actives and /or pre 65 Retirees only.

Inpatient Claims Top 25 DRG – Comparison to Health Plan

Non – Medicare

Region: Northern California

Group Name: HEALTH SERVICE SYSTEM (CITY AND COUNTY OF SF)

Group Numbers: 888

Subgroups: 0000,4900,7000

Contract Period: 01/01/2014 – 12/31/2014

Jan12 – Dec12

Average Members *: 39,043

			Group							Health Plan						
			Admits			Claims				Admits			Claims			
DRG	DRG Label	Category	Count	per 1,000	Days	ALOS	Total Inpatient	PMPM	per Admit	Count	per 1,000	Days	ALOS	Total Inpatient	PMPM	per Admit
Volume																
373	VAGINAL DELIVERY W/O COMPLICATING DIAGNOSES	MAT	192	4.9	438	2.3	$3,002,556	$6.41	$15,638.31	14,649	6.8	28,695	2.0	$198,888,432	$7.65	$13,576.93
430	PSYCHOSES	MH	103	2.6	592	5.7	1,077,637	2.30	10,462.50	3,971	1.8	23,488	5.9	37,367,393	1.44	9,410.07
372	VAGINAL DELIVERY W COMPLICATING DIAGNOSES	MAT	79	2.0	203	2.6	1,386,690	2.96	17,553.03	3,930	1.8	9,672	2.5	65,188,622	2.51	16,587.44
370	CESAREAN SECTION W CC/MCC	MAT	61	1.6	300	4.9	2,112,272	4.51	34,627.40	3,175	1.5	12,386	3.9	95,673,519	3.68	30,133.39
576	SEPTICEMIA W/O MV 96+ HOURS W/ OR W/O MCC	MED	58	1.5	221	3.8	2,098,651	4.48	36,183.64	3,293	1.5	14,334	4.4	133,371,495	5.13	40,501.52
371	CESAREAN SECTION W/O CC/MCC	MAT	58	1.5	188	3.2	1,556,334	3.32	26,833.34	3,562	1.6	11,474	3.2	93,445,703	3.59	26,234.05
544	MAJOR JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY	SURG	57	1.5	137	2.4	3,066,565	6.55	53,799.39	2,972	1.4	7,272	2.4	162,161,821	6.24	54,563.20
014	INTRACRANIAL HEMORRHAGE & STROKE W INFARCT	MED	23	0.6	74	3.2	802,932	1.71	34,910.07	956	0.4	3,835	4.0	37,207,327	1.43	38,919.80
391	NORMAL NEWBORN	MAT	23	0.6	51	2.2	278,570	0.59	12,111.73	1,204	0.6	2,694	2.2	10,636,331	0.41	8,834.16
167	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W/O CC	SURG	20	0.5	26	1.3	525,190	1.12	26,259.52	924	0.4	1,246	1.3	23,513,504	0.90	25,447.51
359	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W/O CC/MCC	SURG	19	0.5	29	1.5	497,043	1.06	26,160.15	998	0.5	1,662	1.7	27,249,366	1.05	27,303.97
204	DISORDERS OF PANCREAS EXCEPT MALIGNANCY	MED	18	0.5	74	4.1	485,975	1.04	26,998.62	852	0.4	3,397	4.0	23,935,787	0.92	28,093.65

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Inpatient Claims Top 25 DRG – Comparison to Health Plan

Non – Medicare

Region: Northern California

Group Name: HEALTH SERVICE SYSTEM (CITY AND COUNTY OF SF)

Group Numbers: 888

Subgroups: 0000,4900,7000

Contract Period: 01/01/2014 – 12/31/2014

Jan12 – Dec12

Average Members *: 39,043

			Group							Health Plan						
			Admits				Claims			Admits				Claims		
DRG	DRG Label	Category	Count	per 1,000	Days	ALOS	Total Inpatient	PMPM	per Admit	Count	per 1,000	Days	ALOS	Total Inpatient	PMPM	per Admit
Volume																
470	UNGROUPABLE	MED	16	0.4	49	3.1	499,804	1.07	31,237.77	1,145	0.5	6,060	5.3	49,860,719	1.92	43,546.48
390	NEONATE W OTHER SIGNIFICANT PROBLEMS	MED	15	0.4	72	4.8	937,018	2.00	62,467.87	988	0.5	3,357	3.4	38,496,945	1.48	38,964.52
388	PREMATURITY W/O MAJOR PROBLEMS	MED	15	0.4	113	7.5	902,650	1.93	60,176.67	570	0.3	4,696	8.2	36,343,965	1.40	63,761.34
557	PERCUTANEOUS CARDIOVASC PROC W DRUG-ELUTING STENT OR 4+ VES/STENTS W MCC	SURG	14	0.4	36	2.6	879,431	1.88	62,816.49	944	0.4	1,774	1.9	53,733,008	2.07	56,920.56
127	HEART FAILURE & SHOCK	MED	13	0.3	80	6.2	562,453	1.20	43,265.60	675	0.3	2,722	4.0	22,412,584	0.86	33,203.83
087	PULMONARY EDEMA & RESPIRATORY FAILURE	MED	13	0.3	42	3.2	392,288	0.84	30,176.00	266	0.1	851	3.2	6,586,118	0.25	24,759.84
426	DEPRESSIVE NEUROSES	MH	13	0.3	40	3.1	49,214	0.11	3,785.66	506	0.2	1,638	3.2	2,436,433	0.09	4,815.08
385	NEONATES DIED OR TRANSFERRED TO ANOTHER ACUTE CARE FACILITY	MED	12	0.3	51	4.3	626,965	1.34	52,247.08	651	0.3	6,287	9.7	74,396,616	2.86	114,280.52
383	OTHER ANTEPARTUM DIAGNOSES W MEDICAL COMPLICATIONS	MAT	12	0.3	39	3.3	218,288	0.47	18,190.63	759	0.4	1,928	2.5	11,636,197	0.45	15,330.96
389	FULL TERM NEONATE W MAJOR PROBLEMS	MED	11	0.3	78	7.1	1,482,618	3.16	134,783.44	513	0.2	2,875	5.6	61,816,002	2.38	120,499.03
277	CELLULITIS WITH MCC	MED	11	0.3	37	3.4	260,868	0.56	23,715.24	321	0.1	1,134	3.5	7,953,704	0.31	24,777.89
174	GI HEMORRHAGE W CC	MED	11	0.3	23	2.1	231,408	0.49	21,037.05	560	0.3	1,645	2.9	15,562,329	0.60	27,789.87

4346

Inpatient Claims Top 25 DRG – Comparison to Health Plan

Non – Medicare

Region: Northern California

Group Name: HEALTH SERVICE SYSTEM (CITY AND COUNTY OF SF)

Contract Period: 01/01/2014 – 12/31/2014

Group Numbers: 888

Subgroups: 0000,4900,7000

Jan12 – Dec12

Average Members *: 39,043

			Group							Health Plan						
			Admits				Claims			Admits				Claims		
DRG	DRG Label	Category	Count	per 1,000	Days	ALOS	Total Inpatient	PMPM	per Admit	Count	per 1,000	Days	ALOS	Total Inpatient	PMPM	per Admit
Volume																
358	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W CC/MCC	SURG	10	0.3	19	1.9	294,471	0.63	29,447.07	424	0.2	1,126	2.7	14,974,649	0.58	35,317.57
	Top DRG: MATERNITY		425	10.9	1,219	2.9	8,554,709	18.26	20,128.73	27,279	12.6	66,849	2.5	475,468,804	18.29	17,429.85
	% of Total Inpatient		25.6%		16.6%			13.4%		28.7%		17.3%			13.2%	
	Top DRG: MEDICAL		216	5.5	914	4.2	9,283,629	19.81	42,979.76	10,790	5.0	51,193	4.7	507,943,591	19.54	47,075.40
	% of Total Inpatient		13.0%		12.5%			14.6%		11.3%		13.2%			14.1%	
	Top DRG: MENTAL HEALTH		116	3.0	632	5.4	1,126,851	2.41	9,714.23	4,477	2.1	25,126	5.6	39,803,826	1.53	8,890.74
	% of Total Inpatient		7.0%		8.6%			1.8%		4.7%		6.5%			1.1%	
	Top DRG: SURGICAL		120	3.1	247	2.1	5,262,700	11.23	43,855.83	6,262	2.9	13,080	2.1	281,632,348	10.83	44,974.82
	% of Total Inpatient		7.2%		3.4%			8.2%		6.6%		3.4%			7.8%	
	All Other DRG		784	20.0	4,317	5.5	39,576,706	84.47	50,480.49	46,259	21.4	230,933	5.0	2,288,459,655	88.03	49,470.58
			47.2%		58.9%			62.0%		48.7%		59.6%			63.7%	
Total Inpatient			1,661	42.5	7,329	4.4	$63,804,595	$136.18	$38,413.36	95,067	43.9	387,181	4.1	$3,593,308,224	$138.23	$37,797.64

4347

* Includes actives and / or pre 65 Retirees Only

Non - Medicare

Inpatient Claims Top 25 DRG - Two-Year Comparison

Region: Northern California

Contract Period: 01/01/2014 - 12/31/2014

Group Name: HEALTH SERVICE SYSTEM (CITY AND COUNTY OF SF)

Group Numbers: 888

Subgroups: 0000,4900,7000

	Jan11 - Dec11	Jan12 - Dec12
Average Members *:	37,307	39,043

DRG	DRG Label	Category	Admits Count	Admits per 1,000	Days	ALOS	Claims Total Inpatient	Claims PMPM	Claims per Admit
Volume					Jan11 - Dec11				
373	VAGINAL DELIVERY W/O COMPLICATING DIAGNOSES	MAT	166	4.5	336	2.0	$2,349,942	$5.25	$14,156.28
430	PSYCHOSES	MH	60	1.6	467	7.8	839,771	1.88	13,996.18
372	VAGINAL DELIVERY W COMPLICATING DIAGNOSES	MAT	73	2.0	170	2.3	1,152,808	2.58	15,791.89
370	CESAREAN SECTION W CC/MCC	MAT	53	1.4	195	3.7	1,481,708	3.31	27,956.75
576	SEPTICEMIA W/O MV 96+ HOURS W/ OR W/O MCC	MED	44	1.2	200	4.5	1,797,184	4.01	40,845.10
371	CESAREAN SECTION W/O CC/MCC	MAT	42	1.1	137	3.3	1,052,044	2.35	25,048.66
544	MAJOR JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY	SURG	48	1.3	126	2.6	2,677,421	5.98	55,779.60
014	INTRACRANIAL HEMORRHAGE & STROKE W INFARCT	MED	26	0.7	122	4.7	1,228,116	2.74	47,235.25
391	NORMAL NEWBORN	MAT	2	0.1	4	2.0	90,627	0.20	45,313.51
167	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W/O CC	SURG	23	0.6	29	1.3	554,484	1.24	24,107.99
359	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W/O CC/MCC	SURG	27	0.7	47	1.7	656,906	1.47	24,329.84
204	DISORDERS OF PANCREAS EXCEPT MALIGNANCY	MED	14	0.4	35	2.5	264,693	0.59	18,906.63

DRG	Admits Count	Admits per 1,000	Admits Day	ALOS	Claims Total Inpatient	Claims PMPM	Claims per Admit
			Jan12 - Dec12				
373	192	4.9	438	2.3	$3,002,556	$6.41	$15,638.31
430	103	2.6	592	5.7	1,077,637	2.30	10,462.50
372	79	2.0	203	2.6	1,386,690	2.96	17,553.03
370	61	1.6	300	4.9	2,112,272	4.51	34,627.40
576	58	1.5	221	3.8	2,098,651	4.48	36,183.64
371	58	1.5	188	3.2	1,556,334	3.32	26,833.34
544	57	1.5	137	2.4	3,066,565	6.55	53,799.39
014	23	0.6	74	3.2	802,932	1.71	34,910.07
391	23	0.6	51	2.2	278,570	0.59	12,111.73
167	20	0.5	26	1.3	525,190	1.12	26,259.52
359	19	0.5	29	1.5	497,043	1.06	26,160.15
204	18	0.5	74	4.1	485,975	1.04	26,998.62

4348

Created On: 4/9/2013

NPS RQR Number: 6425340

SPAS RQR Number/Set ID: 393124-10399-210-1

NPS RQR Name: C1 S1 for EU 0, 7000

Non – Medicare

Inpatient Claims Top 25 DRG – Two-Year Comparison

Region: Northern California

Contract Period: 01/01/2014 – 12/31/2014

Group Name: HEALTH SERVICE SYSTEM (CITY AND COUNTY OF SF)

Group Numbers: 888

Subgroups: 0000,4900,7000

	Jan11 – Dec11	Jan12 – Dec12
Average Members *:	37,307	39,043

DRG	DRG Label	Category	Admits Count	Admits per 1,000	Days	ALOS	Claims Total Inpatient	Claims PMPM	Claims per Admit
Volume							Jan11 – Dec11		
470	UNGROUPABLE	MED	13	0.4	61	4.7	387,429	0.87	29,802.19
390	NEONATE W OTHER SIGNIFICANT PROBLEMS	MED	6	0.2	20	3.3	222,804	0.50	37,133.94
388	PREMATURITY W/O MAJOR PROBLEMS	MED	20	0.5	82	4.1	792,109	$1.77	$39,605.44
557	PERCUTANEOUS CARDIOVASC PROC W DRUG-ELUTING STENT OR 4+ VES/STENTS W MCC	SURG	15	0.4	47	3.1	1,134,467	2.53	75,631.16
127	HEART FAILURE & SHOCK	MED	11	0.3	56	5.1	404,265	0.90	36,751.40
087	PULMONARY EDEMA & RESPIRATORY FAILURE	MED	6	0.2	16	2.7	155,517	0.35	25,919.47
426	DEPRESSIVE NEUROSES	MH	17	0.5	45	2.6	63,795	0.14	3,752.65
385	NEONATES DIED OR TRANSFERRED TO ANOTHER ACUTE CARE FACILITY	MED	2	0.1	3	1.5	60,624	0.14	30,311.76
383	OTHER ANTEPARTUM DIAGNOSES W MEDICAL COMPLICATIONS	MAT	14	0.4	23	1.6	177,299	0.40	12,664.21
389	FULL TERM NEONATE W MAJOR PROBLEMS	MED	14	0.4	74	5.3	1,571,170	3.51	112,226.46
277	CELLULITIS WITH MCC	MED	8	0.2	26	3.3	208,023	0.46	26,002.83
174	GI HEMORRHAGE W CC	MED	11	0.3	31	2.8	276,721	0.62	25,156.47

DRG	Count	Admits per 1,000	Day	ALOS	Claims Total Inpatient	Claims PMPM	Claims per Admit
					Jan12 – Dec12		
470	16	0.4	49	3.1	499,804	1.07	31,237.77
390	15	0.4	72	4.8	937,018	2.00	62,467.87
388	15	0.4	113	7.5	902,650	1.93	$60,176.67
557	14	0.4	36	2.6	879,431	1.88	62,816.49
127	13	0.3	80	6.2	562,453	1.20	43,265.60
087	13	0.3	42	3.2	392,288	0.84	30,176.00
426	13	0.3	40	3.1	49,214	0.11	3,785.66
385	12	0.3	51	4.3	626,965	1.34	52,247.08
383	12	0.3	39	3.3	218,288	0.47	18,190.63
389	11	0.3	78	7.1	1,482,618	3.16	134,783.44
277	11	0.3	37	3.4	260,868	0.56	23,715.24
174	11	0.3	23	2.1	231,408	0.49	21,037.05

4349

Created On: 4/9/2013

NPS RQR Number: 6425340

SPAS RQR Number/Set ID: 393124-10399-210-1

NPS RQR Name: C1 S1 for EU 0, 7000

Non – Medicare

Inpatient Claims Top 25 DRG – Two-Year Comparison

Region: Northern California

Contract Period: 01/01/2014 – 12/31/2014

Group Name: HEALTH SERVICE SYSTEM (CITY AND COUNTY OF SF)

Group Numbers: 888

Subgroups: 0000,4900,7000

	Jan11 – Dec11	Jan12 – Dec12
Average Members *:	37,307	39,043

DRG	DRG Label	Category	Admits Count	Admits per 1,000	Admits Days	Admits ALOS	Claims Total Inpatient	Claims PMPM	Claims per Admit	Admits Count	Admits per 1,000	Admits Day	Admits ALOS	Claims Total Inpatient	Claims PMPM	Claims per Admit
Volume							Jan11 – Dec11							Jan12 – Dec12		
358	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W CC/MCC	SURG	11	0.3	30	2.7	381,064	0.85	34,642.20	10	0.3	19	1.9	294,471	0.63	29,447.07
	Top DRG: MATERNITY		350	9.4	865	2.5	6,304,427	14.08	18,012.65	425	10.9	1,219	2.9	8,554,709	18.26	20,128.73
	% of Total Inpatient		21.9%		12.1%			10.0%		25.6%		16.6%			13.4%	
	Top DRG: MEDICAL		175	4.7	726	4.1	7,368,654	16.46	42,106.60	216	5.5	914	4.2	9,283,629	19.81	42,979.76
	% of Total Inpatient		11.0%		10.1%			11.7%		13.0%		12.5%			14.6%	
	Top DRG: MENTAL HEALTH		77	2.1	512	6.6	903,566	2.02	11,734.62	116	3.0	632	5.4	1,126,851	2.41	9,714.23
	% of Total Inpatient		4.8%		7.2%			1.4%		7.0%		8.6%			1.8%	
	Top DRG: SURGICAL		124	3.3	279	2.3	5,404,342	$12.07	$43,583.40	120	3.1	247	2.1	5,262,700	11.23	$43,855.83
	% of Total Inpatient		7.8%		3.9%			8.6%		7.2%		3.4%			8.2%	
	All Other DRG		869	23.3	4,778	5.5	42,875,330	95.77	49,338.70	784	20.0	4,317	5.5	39,576,706	84.47	50,480.49
			54.5%		66.7%			68.2%		47.2%		58.9%			62.0%	
	Total Inpatient		1,595	42.8	7,160	4.5	$62,856,319	$140.40	$39,408.35	1,661	42.5	7,329	4.4	$63,804,595	$136.18	$38,413.36

4350

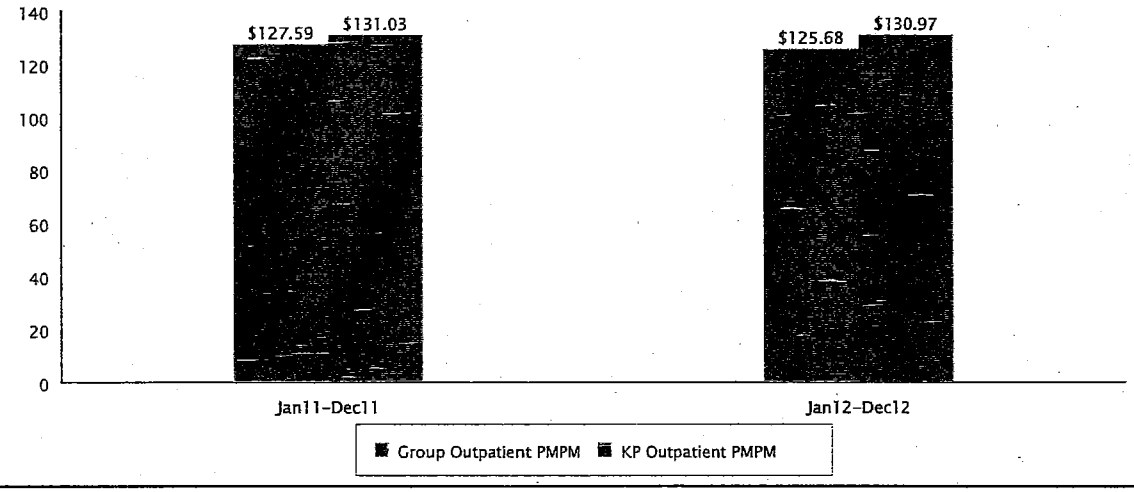
* Includes actives and /or pre 65 Retirees Only.

Outpatient – $ PMPM and $/Visit

Group Name: HEALTH SERVICE SYSTEM (CITY AND COUNTY OF SF)
Region: Northern California
Group Number(s): 888
Contract Period: 01/01/2014 – 12/31/2014
Subgroup(s): 0000,4900,7000

	Jan11 – Dec11	Jan12 – Dec12
Average Members*:	37,307	39,043

Outpatient $ PMPM



Outpatient $ PMPM *

Service Category	Jan11 – Dec11	Change	Jan12 – Dec12
Outpatient Visits	$48.10	(3.6)%	$46.36
Emergency Room	14.66	12.8%	16.54
Surgical/Procedures			
Outpatient Surgery Facility	23.90	12.3%	26.84
Outpatient Surgery Professional	9.05	(5.4)%	8.56
Lab	13.43	(10.2)%	12.06
Radiology	18.46	(17.0)%	15.33
Total Outpatient $ PMPM	**$127.59**	**(1.5)%**	**$125.68**
Group to Health Plan Ratio	97.4%	(1.4)%	96.0%

Outpatient $/Visit *

Service Category	Jan11 – Dec11	Change	Jan12 – Dec12
Outpatient Visits	$135.57	(3.7)%	$130.49
Emergency Room	1,078.54	11.9%	1,206.45
Surgical/Procedures			
Outpatient Surgery Facility	2,683.88	9.8%	2,947.98
Outpatient Surgery Professional	1,016.20	(7.5)%	940.43
Lab	53.95	(10.0)%	48.55
Radiology	309.69	(16.0)%	260.13
Total Outpatient $/Visit	**$186.07**	**(1.5)%**	**$183.37**

* Includes Actives and /or pre 65 Retirees only.

Outpatient – Visits/1000

Group Name: HEALTH SERVICE SYSTEM (CITY AND COUNTY OF SF)

Region: Northern California

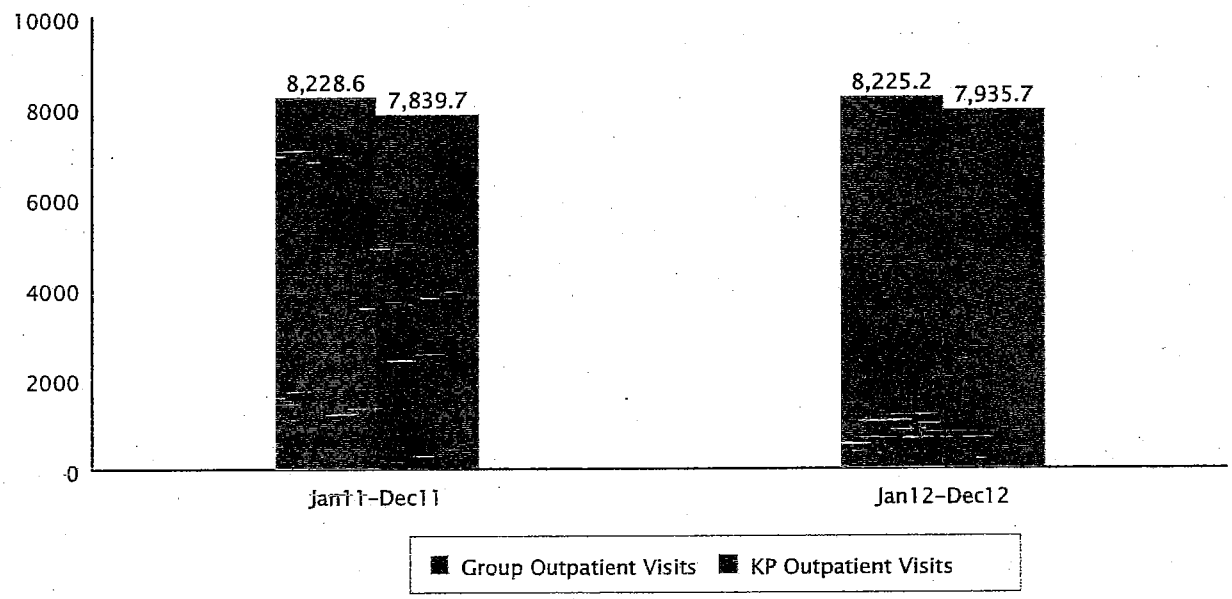
Group Number(s): 888

Contract Period: 01/01/2014–12/31/2014

Subgroup(s): 0000,4900,7000

	Jan11 – Dec11	Jan12 – Dec12
Average Members*:	37,307	39,043

Outpatient Visits/1000



Outpatient Visits/1000 *

Service Category	Jan11 – Dec11	Change	Jan12 – Dec12
Outpatient Visits	4,257.1	0.1%	4,262.9
Emergency Room	163.2	0.8%	164.5
Surgical/Procedures	106.8	2.2%	109.2
Lab	2,986.0	(0.2)%	2,981.4
Radiology	715.5	(1.2)%	707.1
Total Outpatient Visits/1000	**8,228.6**	**0.0%**	**8,225.2**

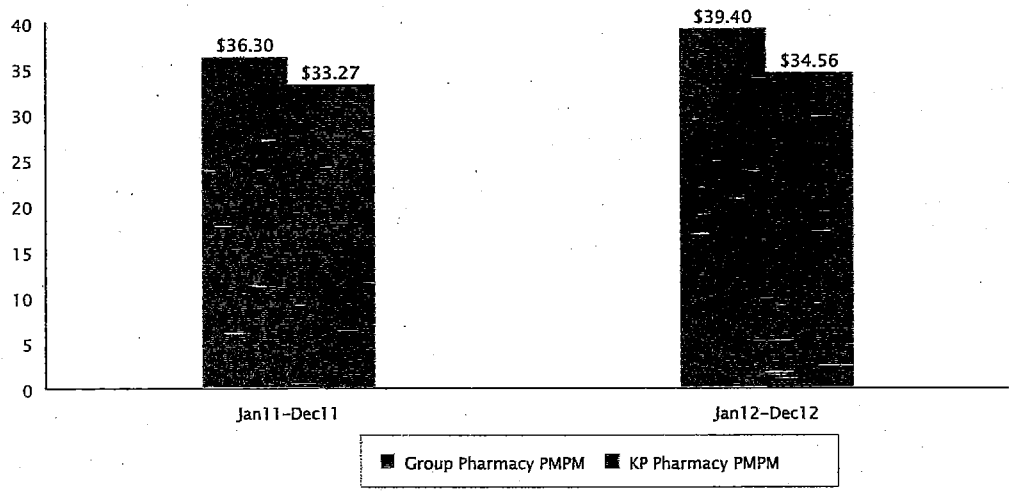
* Includes Actives and /or pre 65 Retirees only.

Pharmacy – $ PMPM and $/Script

Group Name: HEALTH SERVICE SYSTEM (CITY AND COUNTY OF SF)
Region: Northern California
Group Number(s): 888
Contract Period: 01/01/2014-12/31/2014
Subgroup(s): 0000,4900,7000

	Jan11 – Dec11	Jan12 – Dec12
Average Members*:	37,307	39,043

Pharmacy $ PMPM



Pharmacy $ PMPM *

Service Category	Jan11 – Dec11	Change	Jan12 – Dec12
Brand /Formulary	$21.87	9.4%	$23.92
Brand/Non-Formulary	3.15	10.5%	3.48
Generic/Formulary	10.70	7.0%	11.45
Generic/Non-Formulary	0.59	(6.8)%	0.55
Total Pharmacy $ PMPM	**$36.30**	**8.5%**	**$39.40**
Group to Health Plan Ratio	109.1%	4.5%	114.0%

Pharmacy $/Script *

Service Category	Jan11 – Dec11	Change	Jan12 – Dec12
Brand /Formulary	$485.80	21.8%	$591.72
Brand/Non-Formulary	251.63	30.3%	327.90
Generic/Formulary	26.55	8.5%	28.81
Generic/Non-Formulary	55.40	(0.9)%	54.89
Total Pharmacy $/Script	**$77.06**	**11.5%**	**$85.94**

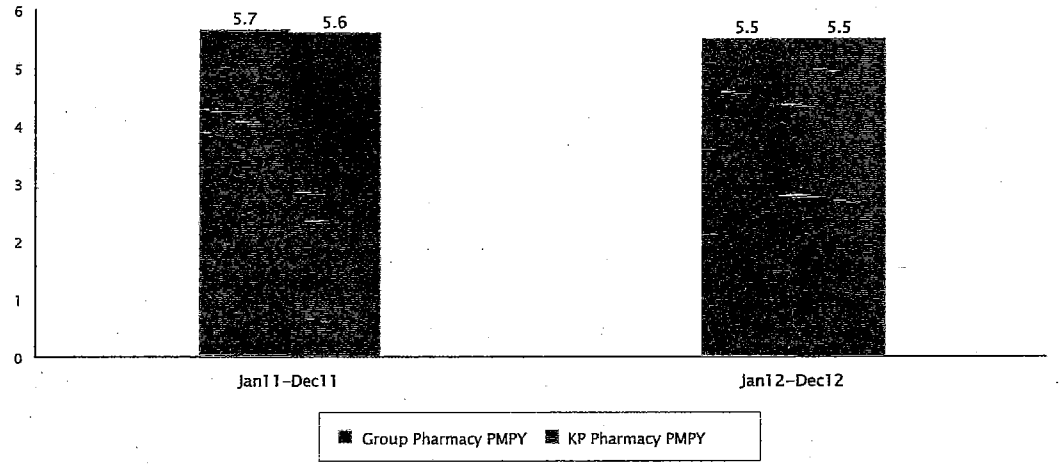
* Includes Actives and /or pre 65 Retirees only.

Pharmacy – Scripts / PMPY

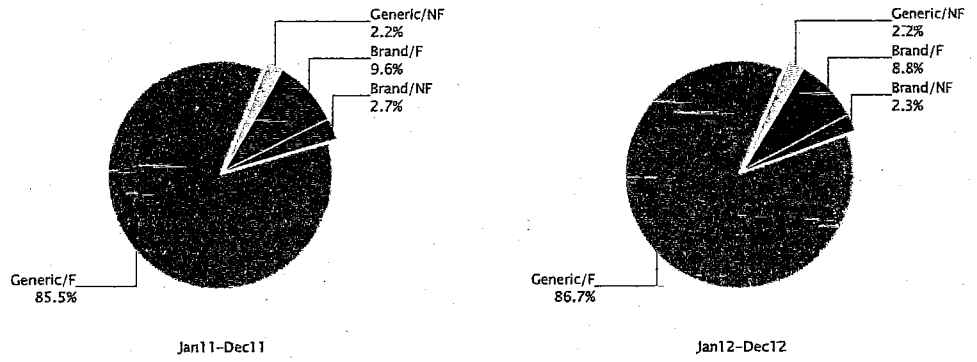
Group Name: HEALTH SERVICE SYSTEM (CITY AND COUNTY OF SF)
Region: Northern California
Group Number(s): 888
Contract Period: 01/01/2014-12/31/2014
Subgroup(s): 0000,4900,7000

	Jan11 – Dec11	Jan12 – Dec12
Average Members*:	37,307	39,043

Pharmacy Scripts PMPY



Pharmacy Scripts Comparison



Pharmacy Scripts PMPY *

Service Category	Jan11 – Dec11	Change	Jan12 – Dec12
Brand /Formulary (F)	0.5	0.0%	0.5
Brand/Non-Formulary (NF)	0.2	(50.0)%	0.1
Generic/Formulary (F)	4.8	0.0%	4.8
Generic/Non-Formulary (NF)	0.1	0.0%	0.1
Total Pharmacy Scripts PMPY	**5.7**	**(3.5)%**	**5.5**

* Includes Actives and /or pre 65 Retirees only.

Pharmacy Detail

Group Name: HEALTH SERVICE SYSTEM (CITY AND COUNTY OF SF)

Region: Northern California

Group Number(s): 888

Contract Period: 01/01/2014-12/31/2014

Subgroup(s): 0000,4900,7000

	Jan12 - Dec12
Average Members *:	39,043

	GENERIC						BRAND						TOTAL					
	$ Claims	% of Total Rx Claims	PMPM Claims	Scripts	% of Total Scripts	$ per Script	$ Claims	% of Total Rx Claims	PMPM Claims	Scripts	% of Total Scripts	$ per Script	$ Claims	% of Total Rx Claims	PMPM Claims	Scripts	% of Total Scripts	$ per Script
Formulary	$5,365,401	29.1%	$11.45	186,206	86.7%	$28.81	$11,208,411	60.7%	$23.92	18,942	8.8%	$591.72	$16,573,812	89.8%	$35.38	205,148	95.5%	$80.79
Non-Formulary	258,476	1.4%	0.55	4,709	2.2%	54.89	1,628,702	8.8%	3.48	4,967	2.3%	327.90	1,887,178	10.2%	4.03	9,676	4.5%	195.04
Rx Total	**$5,623,877**	**30.5%**	**$12.00**	**190,915**	**88.9%**	**$29.46**	**$12,837,113**	**69.5%**	**$27.40**	**23,909**	**11.1%**	**$536.92**	**$18,460,990**	**100.0%**	**$39.40**	**214,824**	**100.0%**	**$85.94**

* Includes actives and /or pre 65 Retirees Only.

4355

Created on: 4/9/2013

SPAS RQR Number/Set ID: 393124-10399-210-1

NPS RQR Number: 6425340

NPS RQR Name: C1 S1 for EU 0, 7000

Non – Medicare

Top 25 Drugs by Total Scripts

Group Name: HEALTH SERVICE SYSTEM (CITY AND COUNTY OF SF)

Group Number: 888

Subgroups: 0000,4900,7000

Region: Northern California

Contract Period: 01/01/2014 – 12/31/2014

Jan12 – Dec12

Average Members *: 39,043

Therapeutic Class	NDC	Drug Name	Brand/ Generic	Formulary /Non- For mulary	Annual Scripts per Member	Group			Health Plan	
						Scripts	Rank	% of Total Scripts	Rank	% of Total Scripts
RESPIRATORY THERAPY AGENTS	59310057920	PROAIR HFA 90 MCG/ACTUATION HFAA	B	F	0.15	6,041	1	2.8%	2	2.6 %
RESPIRATORY THERAPY AGENTS	60505085003	FLUTICASONE 50 MCG/ACTUATION SPSN	G	F	0.15	5,728	2	2.7%	1	2.6 %
ANALGESIC, ANTI-INFLAMMATORY OR ANTIPYRETIC	00603388128	HYDROCODONE-ACETAMINOPHEN 5-500 MG TAB	G	F	0.10	3,811	3	1.8%	3	1.9 %
CARDIOVASCULAR THERAPY AGENTS	29300012810	HYDROCHLOROTHIAZIDE 25 MG TAB	G	F	0.08	3,133	4	1.5%	4	1.3 %
ENDOCRINE	65862000801	METFORMIN 500 MG TAB	G	F	0.06	2,508	5	1.2%	10	0.9 %
RESPIRATORY THERAPY AGENTS	59310020480	QVAR 80 MCG/ACTUATION AERO	B	F	0.06	2,477	6	1.2%	6	1.1 %
RESPIRATORY THERAPY AGENTS	00603107556	CHERATUSSIN AC 10-100 MG/5 ML LIQD	G	F	0.06	2,203	7	1.0%	14	0.7 %
DRUGS TO TREAT ERECTILE DYFUNCTION	00173083113	LEVITRA 20 MG TAB	B	F	0.06	2,173	8	1.0%	16	0.7 %
GASTROINTESTINAL THERAPY AGENTS	62175011843	OMEPRAZOLE 20 MG CPDR	G	F	0.05	2,030	9	0.9%	9	0.9 %
CARDIOVASCULAR THERAPY AGENTS	00093715510	SIMVASTATIN 40 MG TAB	G	F	0.05	1,982	10	0.9%	11	0.9 %
ANTI-INFECTIVE AGENTS	00143993901	AMOXICILLIN 500 MG CAP	G	F	0.05	1,947	11	0.9%	7	0.9 %
ANALGESIC, ANTI-INFLAMMATORY OR ANTIPYRETIC	55111068301	IBUPROFEN 600 MG TAB	G	F	0.05	1,934	12	0.9%	13	0.7 %
CARDIOVASCULAR THERAPY AGENTS	00093078710	ATENOLOL 25 MG TAB	G	F	0.05	1,925	13	0.9%	12	0.8 %
ANALGESIC, ANTI-INFLAMMATORY OR ANTIPYRETIC	55111068401	IBUPROFEN 800 MG TAB	G	F	0.05	1,906	14	0.9%	5	1.2 %

Created On: 4/9/2013

NPS RQR Number: 6425340

SPAS RQR Number/Set ID: 393124-10399-210-1

NPS RQR Name: C1 S1 for EU 0, 7000

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Non – Medicare

Top 25 Drugs by Total Scripts

Group Name: HEALTH SERVICE SYSTEM (CITY AND COUNTY OF SF)

Group Number: 888

Subgroups: 0000,4900,7000

Region: Northern California

Contract Period: 01/01/2014 – 12/31/2014

Jan12 – Dec12

Average Members *: 39,043

Therapeutic Class	NDC	Drug Name	Brand/ Generic	Formulary /Non- For mulary	Annual Scripts per Member	Group Scripts	Group Rank	Group % of Total Scripts	Health Plan Rank	Health Plan % of Total Scripts
CARDIOVASCULAR THERAPY AGENTS	59762153003	AMLODIPINE 5 MG TAB	G	F	0.04	1,585	15	0.7%	20	0.6 %
CONTRACEPTIVES	52544027928	LEVORA-28 0.15-30 MG-MCG TAB	G	F	0.04	1,506	16	0.7%	15	0.7 %
ENDOCRINE	65862001001	METFORMIN 1,000 MG TAB	G	F	0.03	1,350	17	0.6%	28	0.5 %
GASTROINTESTINAL THERAPY AGENTS	62175011837	OMEPRAZOLE 20 MG CPDR	G	F	0.03	1,298	18	0.6%	32	0.5 %
ANTI-INFECTIVE AGENTS	00143989701	CEPHALEXIN 500 MG CAP	G	F	0.03	1,277	19	0.6%	19	0.6 %
CARDIOVASCULAR THERAPY AGENTS	00093075210	ATENOLOL 50 MG TAB	G	F	0.03	1,240	20	0.6%	21	0.6 %
CARDIOVASCULAR THERAPY AGENTS	00093715410	SIMVASTATIN 20 MG TAB	G	F	0.03	1,223	21	0.6%	18	0.6 %
ANALGESIC, ANTI-INFLAMMATORY OR ANTIPYRETIC	00406036701	HYDROCODONE-ACETAMINOPHEN 10-325 MG TAB	G	F	0.03	1,197	22	0.6%	8	0.9 %
CARDIOVASCULAR THERAPY AGENTS	59762154003	AMLODIPINE 10 MG TAB	G	F	0.03	1,197	23	0.6%	35	0.4 %
ANALGESIC, ANTI-INFLAMMATORY OR ANTIPYRETIC	00406051201	OXYCODONE-ACETAMINOPHEN 5-325 MG TAB	G	F	0.03	1,160	24	0.5%	27	0.5 %
ANTI-INFECTIVE AGENTS	00172531260	CIPROFLOXACIN 500 MG TAB	G	F	0.03	1,115	25	0.5%	31	0.5 %
		ALL OTHER			4.12	160,878		74.9%		76.5 %
	TOTAL:				5.50	214,824		100.0 %		100.0 %

* Includes actives and /or pre 65 Retirees Only.

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Top 25 Drugs by Net Claims

Group Name: HEALTH SERVICE SYSTEM (CITY AND COUNTY OF SF)

Group Number: 888

Subgroups: 0000,4900,7000

Region: Northern California

Contract Period: 01/01/2014 - 12/31/2014

Average Members *: Jan12 - Dec12: 39,043

Therapeutic Class	NDC	Drug Name	Brand/ Generic	Formulary /Non- For mulary	% of Total Net Claims	Group			Health Plan	
						Net Claims	Rank	Net Claims Per Script	Rank	Net Claims Per Script
ANTI-INFECTIVE AGENTS	15584010101	ATRIPLA 600-200-300 MG TAB	B	F	5.8%	$1,062,643.60	1	$4,040.47	1	$3,546.61
ANTI-INFECTIVE AGENTS	61958070101	TRUVADA 200-300 MG TAB	B	F	4.3%	794,036.85	2	2,443.19	3	2,081.88
METABOLIC DISEASE ENZYME REPLACEMENT AGENTS	57665000101	ADAGEN 250 UNIT/ML SOLN	B	N	2.1%	380,854.20	3	63,475.70	184	102,894.40
ANTI-INFECTIVE AGENTS	00003362212	REYATAZ 300 MG CAP	B	F	2.1%	380,835.00	4	2,294.19	20	1,877.14
MULTIPLE SCLEROSIS AGENTS	59627000205	AVONEX ADMINISTRATION PACK 30 MCG/0.5 ML KIT	B	F	1.8%	339,814.30	5	3,267.45	6	3,262.60
ANTI-INFECTIVE AGENTS	00085031402	VICTRELIS 200 MG CAP	B	F	1.7%	315,530.10	6	4,322.33	31	4,402.35
ANTI-INFECTIVE AGENTS	00006022761	ISENTRESS 400 MG TAB	B	F	1.6%	294,121.60	7	2,352.97	14	1,897.49
ANTI-INFECTIVE AGENTS	00003161112	BARACLUDE 0.5 MG TAB	B	F	1.4%	259,834.90	8	2,572.62	13	2,596.57
ANALGESIC, ANTI-INFLAMMATORY OR ANTIPYRETIC	00074379902	HUMIRA 40 MG/0.8 ML KIT	B	F	1.4%	258,437.45	9	2,135.85	5	2,100.25
ANTI-INFECTIVE AGENTS	61958040101	VIREAD 300 MG TAB	B	F	1.3%	245,960.61	10	1,720.00	23	1,753.37
ANTI-INFECTIVE AGENTS	49702020613	EPZICOM 600-300 MG TAB	B	F	1.3%	241,509.43	11	2,300.09	44	1,977.42
CENTRAL NERVOUS SYSTEM AGENTS	68727010001	XYREM 500 MG/ML SOLN	B	N	1.2%	219,484.07	12	5,627.80	97	5,192.62
ANALGESIC, ANTI-INFLAMMATORY OR ANTIPYRETIC	58406043504	ENBREL 50 MG/ML (0.98 ML) SYRG	B	F	1.1%	208,560.55	13	1,862.15	4	1,942.13

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Non – Medicare

Top 25 Drugs by Net Claims

Group Name: HEALTH SERVICE SYSTEM (CITY AND COUNTY OF SF)

Group Number: 888

Subgroups: 0000,4900,7000

Region: Northern California

Contract Period: 01/01/2014 – 12/31/2014

Average Members *: Jan12 – Dec12 39,043

Therapeutic Class	NDC	Drug Name	Brand/ Generic	Formulary /Non- For mulary	% of Total Net Claims	Group Net Claims	Group Rank	Group Net Claims Per Script	Health Plan Rank	Health Plan Net Claims Per Script
MULTIPLE SCLEROSIS AGENTS	68546031730	COPAXONE 20 MG KIT	B	F	1.0%	186,929.05	14	3,814.88	2	3,792.75
CARDIOVASCULAR THERAPY AGENTS	66215010206	TRACLEER 125 MG TAB	B	F	0.9%	172,586.85	15	6,392.11	122	6,399.38
ANALGESIC, ANTI-INFLAMMATORY OR ANTIPYRETIC	00074433902	HUMIRA PEN 40 MG/0.8 ML PNKT	B	F	0.9%	161,516.30	16	1,994.03	11	2,050.03
RESPIRATORY THERAPY AGENTS	59310020480	QVAR 80 MCG/ACTUATION AERO	B	F	0.8%	155,605.23	17	62.82	16	60.17
HEMATOLOGICAL AGENTS	55513092410	NEUPOGEN 300 MCG/0.5 ML SYRG	B	F	0.8%	153,974.45	18	2,199.64	22	2,044.85
DRUGS TO TREAT ERECTILE DYFUNCTION	00173083113	LEVITRA 20 MG TAB	B	F	0.8%	150,090.26	19	69.07	21	73.47
ENDOCRINE	00169750111	NOVOLOG 100 UNIT/ML SOLN	B	F	0.8%	146,221.90	20	509.48	10	429.01
ANALGESIC, ANTI-INFLAMMATORY OR ANTIPYRETIC	58406044504	ENBREL SURECLICK 50 MG/ML (0.98 ML) PNIJ	B	F	0.8%	143,665.40	21	1,915.54	7	1,974.49
ENDOCRINE	00088222033	LANTUS 100 UNIT/ML SOLN	B	F	0.8%	140,269.85	22	394.02	12	423.27
RESPIRATORY THERAPY AGENTS	59310057920	PROAIR HFA 90 MCG/ACTUATION HFAA	B	F	0.8%	139,705.24	23	23.13	19	21.26
ANTI-INFECTIVE AGENTS	00074333330	NORVIR 100 MG TAB	B	F	0.7%	135,339.72	24	588.43	46	601.72
ANTI-INFECTIVE AGENTS	00004035730	PEGASYS 180 MCG/0.5 ML SYRG	B	F	0.7%	134,959.85	25	1,928.00	41	2,074.58
		ALL OTHER			63.0%	$11,638,503.36		$57.84		$60.59
	TOTAL:				100.0 %	$18,460,990.12		$85.94		$75.14

* Includes actives and /or pre 65 Retirees Only.

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Created On: 4/9/2013
NPS RQR Number: 6425340

SPAS RQR Number/Set ID: 393124-10399-210-1
NPS RQR Name: C1 S1 for EU 0, 7000

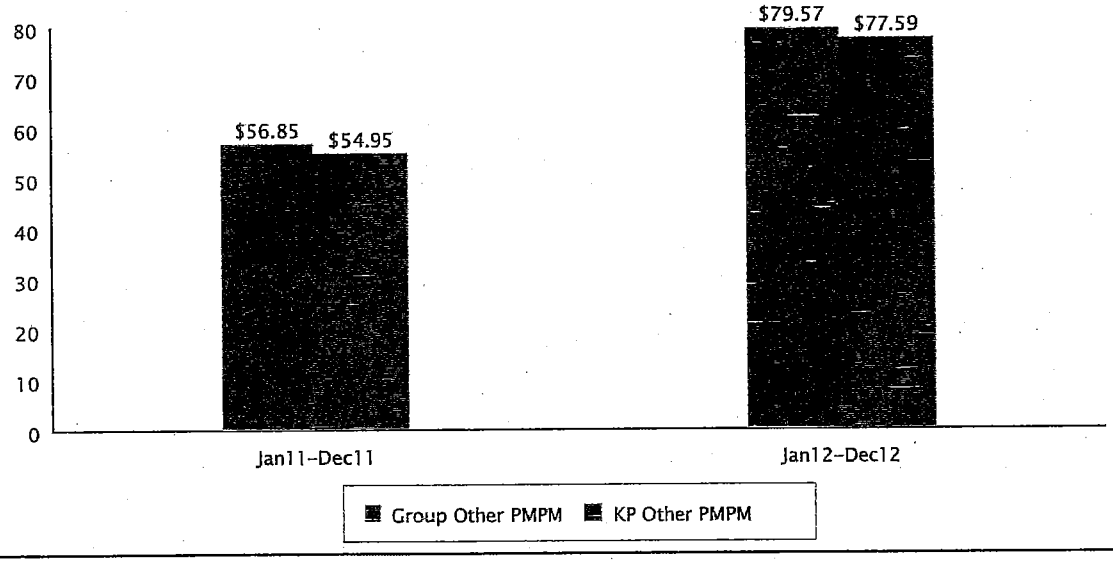
Other – $ PMPM

Group Name: HEALTH SERVICE SYSTEM (CITY AND COUNTY OF SF)
Group Number(s): 888
Subgroup(s): 0000,4900,7000

Region: Northern California
Contract Period: 01/01/2014-12/31/2014

	Jan11 – Dec11	Jan12 – Dec12
Average Members*:	37,307	39,043

Other $ PMPM



Other $ PMPM *

Service Category	Jan11 – Dec11	Change	Jan12 – Dec12
Ambulance	$4.17	8.9%	$4.54
DME	2.85	4.2%	2.97
Home Health	0.83	(16.9)%	0.69
Integrated Care Management – Variable – Rx	0.00	N/A	9.73
Integrated Care Management – Variable – Medical	0.00	N/A	26.35
Integrated Care Management – Fixed	27.50	(34.5)%	18.02
Other Medical Services	21.50	(19.7)%	17.27
Total Other $ PMPM	**$56.85**	**40.0%**	**$79.57**
Group to Health Plan Ratio	103.5%	(0.9)%	102.6%

* Includes Actives and/or pre 65 Retirees only.

High Cost Claimants

Region: Northern California
Contract Period: 01/01/2014-12/31/2014

Group Name: HEALTH SERVICE SYSTEM (CITY AND COUNTY OF SF)
Group Number(s): 888
Subgroup(s): 0000,4900,7000

Jan12 - Dec12
Average Members*: 39,043

Product Type: HMO

Claims In Excess Of: $550,000
Pooling Point: $550,000

Person	Member Status	Primary Diagnosis	Claims Per Member	% of Total Claims	Claims Over Pooling Point
Person 1	Active	0389-UNSPECIFIED SEPTICEMIA	$1,975,690.37	1.1%	$1,425,690.37
Person 2	Active	0389-UNSPECIFIED SEPTICEMIA	901,739.17	0.5%	351,739.17
Person 3	Active	57400-CALCU GALLBLADD W/ACUT CHOLCYST W/O MENTION OBST	752,508.08	0.4%	202,508.08
Person 4	Active	3481-ANOXIC BRAIN DAMAGE	685,129.61	0.4%	135,129.61
Person 5	Active	V5811-ENCOUNTER FOR ANTINEOPLASTIC CHEMOTHERAPY	725,499.98	0.4%	175,499.98
Person 6	Active	V5811-ENCOUNTER FOR ANTINEOPLASTIC CHEMOTHERAPY	667,480.41	0.4%	117,480.41
Person 7	Active	V3001-SINGLE LIVEBORN HOSPITAL DELIV BY C-SECTION	647,830.30	0.4%	97,830.30
Person 8	Active	0463-PROGRESSIVE MULTIFOCAL LEUKOENCEPHALOPATHY	610,800.49	0.3%	60,800.49
Total for High Cost Members:			$6,966,687.41	3.9 %	
All Other Claimants Total:			$171,465,385.64	96.1 %	
Total for All Claimants:			$178,432,064.05	100.0 %	$2,566,678.41

* Includes Actives and /or pre 65 Retirees Only.

Monthly Paid Claims

Non-Medicare

Region: Northern California

Contract Period: 01/01/2014 - 12/31/2014

Group Name: HEALTH SERVICE SYSTEM (CITY AND COUNTY OF SF)
Group Numbers: 888
Subgroups: 0000,4900,7000

	Jan11 - Dec11	Jan12 - Dec12
Average Members *:	37,307	39,043

	Medical Claims			Total Medical Claims	Rx Claims	Total Claims	PMPM Claims	Members
	Inpatient	Outpatient	Other					
Jan 12	$3,481,510	$4,309,078	$2,960,313	$10,750,901	$1,492,594	$12,243,495	$318.58	38,432
Feb 12	5,006,036	4,329,229	2,962,512	12,297,777	1,540,280	13,838,058	359.52	38,490
Mar 12	5,662,881	4,968,124	3,214,138	13,845,143	1,753,372	15,598,515	402.25	38,778
Apr 12	6,538,063	5,112,071	3,171,709	14,821,843	1,413,621	16,235,464	418.62	38,783
May 12	5,717,879	5,238,060	3,251,559	14,207,498	1,606,398	15,813,896	407.56	38,801
Jun 12	4,984,792	5,308,449	3,013,832	13,307,074	1,547,750	14,854,823	383.05	38,780
Jul 12	4,733,357	4,834,236	3,013,308	12,580,901	1,451,623	14,032,525	358.79	39,111
Aug 12	5,699,099	5,153,764	3,282,670	14,135,533	1,656,822	15,792,355	403.30	39,158
Sep 12	4,598,952	4,432,466	3,074,583	12,106,000	1,517,064	13,623,065	344.60	39,533
Oct 12	5,341,483	5,331,499	3,175,576	13,848,558	1,593,578	15,442,136	390.10	39,585
Nov 12	3,908,231	5,101,797	2,987,370	11,997,398	1,425,169	13,422,567	340.16	39,460
Dec 12	8,132,311	4,766,352	3,173,784	16,072,447	1,462,718	17,535,165	442.75	39,605
Total	$63,804,595	$58,885,125	$37,281,354	$159,971,074	$18,460,990	$178,432,064	$380.85	468,516
Jan 11	$4,531,080	$4,583,853	$2,013,427	$11,128,361	$1,275,058	$12,403,419	$340.90	36,384
Feb 11	5,638,279	4,512,057	2,017,627	12,167,963	1,319,742	13,487,705	370.94	36,361
Mar 11	7,303,862	5,000,844	2,155,636	14,460,342	1,443,023	15,903,365	436.70	36,417
Apr 11	5,157,789	4,884,584	2,058,795	12,101,168	1,285,743	13,386,911	366.18	36,558
May 11	3,890,779	4,404,198	2,093,074	10,388,052	1,376,522	11,764,573	321.31	36,614
Jun 11	4,882,761	5,211,291	2,099,534	12,193,586	1,371,899	13,565,486	370.17	36,647
Jul 11	6,399,390	4,485,156	2,193,344	13,077,890	1,286,623	14,364,513	381.30	37,672
Aug 11	4,801,023	5,503,890	2,159,621	12,464,535	1,394,862	13,859,397	366.68	37,797
Sep 11	4,080,669	4,648,262	2,189,024	10,917,954	1,308,553	12,226,507	320.59	38,138
Oct 11	7,872,344	4,540,600	2,157,445	14,570,389	1,437,807	16,008,196	418.23	38,276
Nov 11	4,344,615	4,682,725	2,118,322	11,145,663	1,335,896	12,481,558	325.52	38,344
Dec 11	3,953,727	4,664,587	2,193,561	10,811,875	1,416,969	12,228,844	317.81	38,479
Total	$62,856,319	$57,122,048	$25,449,410	$145,427,777	$16,252,696	$161,680,473	$361.15	447,687

* Includes actives and /or pre 65 Retirees Only.

Rate and Benefit Summary – Commercial

Region: Northern California

Group Name: HEALTH SERVICE SYSTEM (CITY AND COUNTY OF SF)

Contract Period: 01/01/2014 – 12/31/2014

Group Numbers: 888

Subgroups: 0000,4900,7000,8500,9900

	Jan11 – Dec11	Jan12 – Dec12
Average Members*:	37,307	39,043

Product Type: HMO

Quote Name: TRADITIONAL PLAN

Current Rates

Rate Tiers	Medical	Chiro	Dental	Total	Ratio
Subscriber only	$529.87	$1.32	$0.00	$531.19	1.00
Subscriber and 1 dependent	1,059.74	2.64	0.00	1,062.38	2.00
Subscriber and 2 or more dependents	1,499.54	3.73	0.00	1,503.27	2.83

Proposed Rates

Rate Tiers	Subscribers	Medical	%Change	Chiro	%Change	Dental	%Change	Total	%Change	Ratio
Subscriber only	8,336	$557.75	5.26%	$1.32	0.00%	$0.00	0.00%	$559.07	5.25%	1.00
Subscriber and 1 dependent	5,213	1,115.50	5.26%	2.64	0.00%	0.00	0.00%	1,118.14	5.25%	2.00
Subscriber and 2 or more dependents	5,509	1,578.43	5.26%	3.74	0.27%	0.00	0.00%	1,582.17	5.25%	2.83

Estimated Monthly Cost: $19,205,446

Billing Frequency: Monthly

Unassigned 65 + Retiree Rates – Single

	Rate	Members
Neither A nor B	$559.07	0
A and B	559.07	0
A Only	559.07	0
B Only	559.07	0
Under 65 NKR	559.07	0
65 Plus NKR	559.07	0

Proposed HMO Benefits

Annual Deductible: Individual / Family per calendar year(s) : None

Out-of-Pocket Maximum: Individual / Family : $1500 per member / $3000 per family

Lifetime Maximum: Individual / Family : None

Prescription Drugs : R:HC2:2T:$15/$5/30 DAY;$30/$10 100 DAY MOI;50% MR INF,IMPOT,RXGZIVF

Outpatient

Provider Visits : HC2 $20/VISIT; $0 PREVENTIVE

Other Professional

Surgery – Outpatient Services : R: HC2 $35/PROCEDURE; $20/ABORTION; $0 COLONOSCOPY; TG, STER

Special Procedures : HCR $0 OUTPT/ENCOUNTER

Chiropractic : $15/VISIT TO 30 VISITS; $50 ALLOW/CALNDR YR

Infertility : $20/VISIT; $100/ADMIT; $0 LAB, IMAG & SPEC/ENCOUNTER

Multidisciplinary Rehab – Inpatient & Outpatient : $20/DAY OUTP; $100/ADMIT INPT

Therapy Services : $20/VISIT

Home Health Services : $0/VISIT PART TIME INTERMITTENT CARE; 3 VISITS/DAY; 100 VISITS/YR

Hospice : $0/SERVICE

Ambulance and Emergency Services

Medical Transportation Services : $0/TRIP

Emergency Care : $100/VISIT

* Includes Actives and/or pre 65 Retirees only.

Rate and Benefit Summary – Commercial

Region: Northern California

Group Name: HEALTH SERVICE SYSTEM (CITY AND COUNTY OF SF)

Contract Period: 01/01/2014 - 12/31/2014

Group Numbers: 888

Subgroups: 0000,4900,7000,8500,9900

	Jan11 – Dec11	Jan12 – Dec12
Average Members*:	37,307	39,043

Product Type: HMO

Quote Name: TRADITIONAL PLAN

Laboratory and Imaging	
Laboratory Services :	HCR $0 OUTPT/ENCOUNTER; $0 PREVENTIVE
Diagnostic and Therapeutic Imaging :	HCR $0/ENCOUNTER; $0 CT/MRI/PET/PROCEDURE; $0 PREVENTIVE
Hospital Inpatient	
Hospital Services :	R: $100/ADMIT; $100 TRANSGENDER
Extended Care :	$0/ADMIT TO 100 DAYS/BNFT PRD
Mental Health and Chemical Dependency	
Mental Health Outpatient :	$20/UNLIMITED VISITS; AB88
Mental Health Inpatient :	$100/ADMIT; $0 PART; $0 INTN; UNLIMITED
Chemical Dependency Outpatient Program :	$20/VISIT INDV; $5/VISIT GRP, DAY, IOP
Chemical Dependency Inpatient Program :	$100/ADMIT; $100 TRRS/ADMIT; $100 RTP/ADMIT
Other	
Durable Medical Equipment :	HC2 $0 BASE, FORMULARY LIST, AND DMSXDEV
Prosthetics & Orthotics :	$0 BASE; FORMULARY LIST & SPECIAL FOOTWEAR
Optical Dispensing :	R: 25% EYEWR DISCOUNT
Hearing Aids :	$2500 ALLOW/DEVICE; 1 DEVICE/EAR; 2 DEVICE(S)/36 MONTHS
Allergy :	$5 INJECTIONS
Dermatology :	$0/TREATMENT
Health Education :	HCR $0 IND/VISIT; $0 GRP/CLASS; $0 PREVENTIVE

.GY5/CDIP171/CDOP7/CHIR18/DERM5/DME5/DRUG1098/EMRG15/EXTC21/GIFT20/HEAR21/HLTH18/HOME21/HOSP107/HSPC1/IMAG12/INF32/LAB12/MDTR1/MHI
197/MHOP184/OPT251/P&O3/PROV692/RHAB91/SPEC12/SURG435/THER9

* Includes Actives and/or pre 65 Retirees only.

Rate Assumptions and Requirements

Region: Northern California

Group Name: HEALTH SERVICE SYSTEM (CITY AND COUNTY OF SF)

Contract Period: 01/01/2014 – 12/31/2014

Group Numbers: 888

	Jan11 – Dec11	Jan12 – Dec12
Average Members:	37,307	39,043

Subgroups: 0000,4900,7000,8500,9900

KP Offered: Alongside other carrier(s)

Quotes Included

TRADITIONAL PLAN – 10404884
CHIROPRACTIC – 10404887

Proposal Assumptions

The proposed rates and benefits included on the Rate and Benefit Summary page are based on the **participation and contribution requirements** described below. If any of the following are not met, Kaiser Permanente (KP) reserves the right to withdraw our rate proposal, decline coverage, re-rate this proposal or terminate your Group Agreement.

1. **Group-specific requirements:**
   None

2. **Rating Assumptions:**
   Rates assume a 12-month policy period of 1/1/2014 through 12/31/2014 unless otherwise specified above.
   The rates and benefits in this proposal include the Federal Health Care Reform requirements for dependent coverage to age 26 and the elimination of lifetime maximums, including durable medical equipment (DME as defined by Federal Health Care Reform) annual maximums for contracts with renewal dates of October 1, 2010 or later. KP reserves the right to modify the rates and benefits if we receive further clarification of Federal Health Care Reform requirements, or to incorporate other applicable Federal Health Care Reform requirements. In addition, Kaiser Permanente reserves the right to make any change in these rates and benefits due to changes in State or Federal legislation or regulatory action.
   KP reserves the right to rerate if actual enrollment results in a +/–10% change in the rates from what was assumed at the time of this quote. Examples of changes that may impact rates include, but are not limited to, the following:
   a. A change in the demographic factor.
   b. A change in the average family size or subscriber distribution.
   c. A change in the number of subscribers enrolled in KP.
   d. A change in the number of plans offered alongside KP.
   e. A change in the benefit design of a plan offered alongside KP.
   f. A change in the employer contribution formula.
   KP reserves the right to change the rates in the event the employer funds, or offers to fund, all or part of an individual or family deductible, copayment or coinsurance which is applicable under the KP plan unless specifically noted in the Group-Specific Requirements above.

3. **Participation and contribution requirements:**
   a. Proposed rates and benefits assume 75% of overall eligible group employees enroll in a company-sponsored plan excluding those waiving for alternative group coverage.
   b. Proposal assumes employer pays at least 50% of the employee only cost and is non-discriminatory.

4. **Quote assumes KP is offered alongside another health care plan**
   KP must be offered on conditions that are no less favorable than those for other health care plans. Examples include, but are not limited to, the following:
   a. KP is offered to all eligible employees.
   b. KP has access to the employer and to the employees on the same basis as all other health care plans offered.
   c. The employer's contribution formula does not put KP in a disadvantaged position. Acceptable formulas include, but are not limited to, fixed employer dollar or percentage contribution.
   d. Basic and optional benefits such as DME, prescription drugs, and infertility are comparable among all health care plans offered, however, KP will allow preventive services as defined by Health and Human Services (HHS) to vary if specifically approved by underwriting.
   e. KP is not offered alongside plans with pre-existing condition provisions, health condition exceptions or lifetime coverage limits.
   f. If early retirees are covered, the employer offers all health care plans to early retirees on the same basis.
   g. Eligibility rules such as dependent age limits and waiting periods for new hires are the same for all health care plans.

h. No other plan is allowed preferential treatment that adversely affects KP.
i. The number of employee subscribers enrolled in KP must be the greater of 5 or 5% of the total number of employees enrolled in all health plans in regions where KP is offered.
j. Kaiser Permanente must NOT be offered along side an age-rated health care plan.
k. Rate tier ratios and their definitions should be the same among all health plans offered by the group (employer).

5. **Product-specific participation requirements:**

Additional Kaiser Permanente Medicare Senior Advantage (KPSA), Medicare Plus or Medicare Cost Requirements:

a. Members must have Medicare Parts A and B to enroll in Medicare Senior Advantage (KPSA), Medicare Plus or Medicare Cost and be eligible for Medicare rates. Members with only Part B may also enroll but their rates will be subject to a surcharge.
b. Medicare eligible members must reside in the approved Medicare Senior Advantage (KPSA), Medicare Plus or Medicare Cost service areas to receive benefits for the group Medicare Senior Advantage (KPSA), Medicare Plus or Medicare Cost offering.
c. Preliminary Medicare Senior Advantage (KPSA), Medicare Plus or Medicare Cost rates and benefits are subject to change.
d. Medicare Senior Advantage (KPSA), Medicare Plus or Medicare Cost products may not be available for sale in all KP regions.

Additional Out-of-Area Product Requirements:

a. All employees offered KP Out-of-Area products must reside and work outside the KP service area.

6. **Proposal requires eligibility for KP plan based on the following:**

a. Employer - the employer cannot be considered a small group according to state law.
b. Actives:
   - The group (employer) must be related to those offered a KP plan by virtue of employment. This includes when the group contract is with a Taft-Hartley Trust, Professional Employer Organization (PEO), association or Joint Power of Authority (JPA).
   - An eligible employee is defined as an active, permanent employee who is on the employer's payroll, and working a minimum of 20 hours per week. Temporary and independent contractors (i.e., 1099 employees) are not eligible unless noted otherwise in this Rate Assumptions and Requirements document.
   - The employee must live or work in the service area specific to the product they enroll in.
   - 100% of eligible employees must be covered by Worker's Compensation, where mandated by law.
c. New enrollees:
   The probationary period for new employees is non-discriminatory and reflects no more than a 90-day waiting period unless noted otherwise in this Rate Assumptions and Requirements document.
d. COBRA
   - It is the responsibility of the employer group to enroll eligible members into the KP COBRA plan in compliance with federal law.
   - It is the employer's responsibility to comply with appropriate COBRA statutes.
   - KP will generally include COBRA members as part of the group bill. If individual billing has been arranged, KP will assume responsibility for collecting premiums from COBRA members, only acting as a collection agent on behalf of the group, not as a fiduciary for the group. In addition, KP retains the authority to terminate a direct-billed member for non-payment.
e. Retirees
   - Eligible early retirees must enroll in a health plan at the time of retirement and may later elect to enroll in a KP plan at open enrollment as long as they have maintained continuous enrollment in a health plan since the time of retirement.
   - Early retirees under the age of 65 must be reported to KP and set up as a separate employee class or subgroup.
   - Medicare eligible retirees cannot enroll in the active plan.
   - Applicants for a Medicare Senior Advantage (KPSA), Medicare Plus or Medicare Cost plan must meet all the Medicare eligibility requirements, including those stated in this Rate Assumptions and Requirements document.
f. Dependents
   - If an "in-area" employee has dependents that live outside the service area, the employee and dependents must be enrolled in the same product.

7. **Compliance:**

KP reserves the right to make any change in the employer group's benefits and/or rates due to changes in State or Federal legislation or regulatory action.

Rate Assumptions and Requirements

Region: Northern California

Group Name: HEALTH SERVICE SYSTEM (CITY AND COUNTY OF SF)

Contract Period: 01/01/2014 - 12/31/2014

Group Numbers: 888

Subgroups: 0000,4900,7000,8500,9900

	Jan11 – Dec11	Jan12 – Dec12
Average Members:	37,307	39,043

KP Offered: Alongside other carrier(s)

8. **Broker Payment:**
Brokers may be paid commissions and other financial incentives by Kaiser Permanente.

The contracting employer must also meet all other group-specific responsibilities and requirements described in your Group Agreement.

Glossary of Terms

Term	Kaiser Foundation Health Plan

Annual Trend	The projected annual percent change in medical and pharmacy expenses applied to a group's claims experience.
Area Factor	A factor that adjusts the manual rate to reflect geographic price differentials.
Average Members	The average monthly membership during the reporting period.
Benefit Adjusted Manual Rate	The average rate for a group's current benefit plan for a particular market segment.
Capping	A method of stabilizing year-to-year rate changes.
COBRA Factor	An adjustment made to the manual rate to reflect the proportion of COBRA enrollees.
Contract Period	The time period during which a rate is valid.
Credibility	The weighting applied to manual, risk or claims-based rates when developing required premium rates.
Demographic Change	An adjustment made in the Projected Claims Calculation to reflect changes in the group demographics that occurred between the experience period and the time of the quote.
Demographic Factor	An adjustment made to the manual rate to reflect a group's current demographics.
Federal Health Insurer Fee	A percent of premium fee paid by insurance carriers for commercial and Medicare business beginning January 1, 2014.
Federal PCORI Fee	A fee per covered life paid by commercial insurers and self-funded plan sponsors to fund the Patient-Centered Outcomes Research Institute (PCORI). PCORI was established by the Affordable Care Act. The PCORI will commission studies that compare drugs, medical devices, tests, surgeries and ways to deliver health care.
Federal Transitional Reinsurance Program Contribution	A fee paid by commercial insurers and third party administrators for self-funded plans from 2014 through 2016 to support reinsurance to individual market insurers covering high risk individuals in Exchanges.
Formulary	A list of preferred drugs based on their effectiveness and value.
Future Benefit Change	An adjustment to the rate to reflect a change in benefits being quoted for the renewal period.
Historical Benefit Change	An adjustment made to historical paid claims to reflect the group's current benefit level.
Incurred Claim Adjustment	An adjustment made to a group's paid claims to convert them to estimated incurred claims.
In-force PMPM Rate	A group's current monthly PMPM (per member per month) rate.
Integrated Care Management (ICM) Fee	This charge, which is currently included in Paid Claims, incorporates services such as chronic conditions management, pharmacy management, clinical access alternatives, telephonic clinical advice, wellness information and coaching, online personal health management, medical and case management, external provider network management, and other care management services that are not billed or can't be done so efficiently. At KP, integrated care management cannot be unbundled, as it is part of the unique care and services the Permanente Medical Groups deliver to get and keep our members healthy.
Kaiser Permanente Senior Advantage (KPSA)	Kaiser Permanente's Medicare Advantage plan, offered in all regions except Ohio and Mid-Atlantic, which offer Medicare Plus (Cost) instead.
Kaiser Permanente Medicare Plus (Cost)	Kaiser Permanente's Medicare Cost plan, offered in Ohio and Mid-Atlantic only. No Medicare Advantage plan is offered in these regions.
Late Payment Charge	A fee added to the rate to compensate KP for a group's late payment history.
Market Segment	Group divisions based on group size and/or line of business such as Labor Trust or National Accounts.
Other Benefits	Benefits that are not included in the manual rate nor in the paid claims.

Glossary of Terms

Term	Kaiser Foundation Health Plan

Other Medical Services (OMS)	Other Medical Services (OMS) is a component of claims that accounts for services that are not easily captured in our claims and encounter systems. OMS includes but is not limited to capitated services, incomplete coding of KP services, COB and third-party liability.
Paid Claims	Paid medical expenses for services provided to a health plan member. These are either the result of an internal service, where prices are based on a fee schedule, or an external claim for services from a non-KP provider. Claims are attributed to the month in which they were paid (external) or reported (internal).
Pooling Charge	The per member per month charge included in the Projected Claims Calculation to compensate for the removal of claims exceeding the pooling point.
Pooling Credit	The total combined medical and prescription drug claims paid above the pooling point. This amount is removed from paid claims in the Projected Claims Calculation.
Pooling Point	The annual threshold above which a member's combined medical and prescription drug claims will be excluded from the group's rate calculation.
Quoted Rate	The renewal rate calculated on a per member per month basis.
Rate Assumptions and Requirements	A component of the customer renewal report package that documents terms and conditions of the rate proposal.
Rating Members	The membership during the rating month used in the renewal.
Rating Month	The month of the membership and benefits used to calculate the renewal.
Report Period	The period of time over which prior claims are aggregated and used to project future claim costs.
Reporting Threshold	Used on the High Cost Claimants report, it is the minimum in total claims in the reporting period required for a member to be displayed. The threshold varies by group size.
Retention	The portion of premium retained by KP to cover Health Plan administration expenses such as billing, member services and marketing.
Risk Factor	A comparison of a group's projected medical expenses to the average based on the group members' demographics and experience period prescription drug use.
Trend Factor	A factor that projects historical claims to a future rating period.
Underwriter Adjustment	An adjustment to the rate made by the underwriter to reflect differences in risk or offering conditions not accounted for elsewhere in the rate development.
Work Status Factor	An adjustment made to the manual rate to reflect the under 65 retiree population's influence on projected medical expenses.

RATE PROPOSAL

HEALTH SERVICE SYSTEM (CITY AND COUNTY OF SF)

Effective from 01/01/2014 through 12/31/2014

Region(s)	Group(s)	Subgroup(s)
Northern California	888	0001, 7001

Table of Contents

Executive Summary

Group Name: HEALTH SERVICE SYSTEM (CITY AND COUNTY OF SF)
Group Number(s): 888
Subgroup(s): 0001,7001

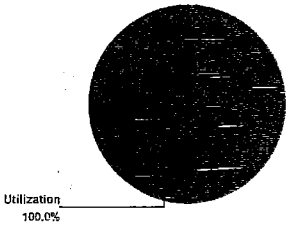
Region: Northern California
Contract Period: 01/01/2014 – 12/31/2014

	Jan11 – Dec11	Jan12 – Dec12
Average Members*:	4,670	4,605

Rates**

	Current Rates	Change %	Proposed Rates
TRADITIONAL HMO: **$20 OV; $100/ADMISSION IP; $100 ER; OPT; CHIRO; HEAR;**			
Subscriber only	$1,072.27	5.26%	$1,128.63
Subscriber and 1 dependent	1,603.46	5.25%	1,687.70
Subscriber and 2 or more dependents	2,044.35	5.25%	2,151.73

Credibility



Claims Summary $PMPM*

TRADITIONAL HMO:

Major Service Category	Jan11 – Dec11	Change	Jan12 – Dec12
Inpatient	$315.09	(5.4)%	$297.97
Outpatient	210.68	2.4%	215.75
Pharmacy	77.74	7.5%	83.56
Other	66.12	97.5%	130.60
Total Claims Summary $PMPM	**$669.62**	**8.7%**	**$727.89**

* Includes Actives and /or pre 65 Retirees only.
**Benefit plan descriptions are summarized, please see Rate and Benefit Summary for full descriptions.

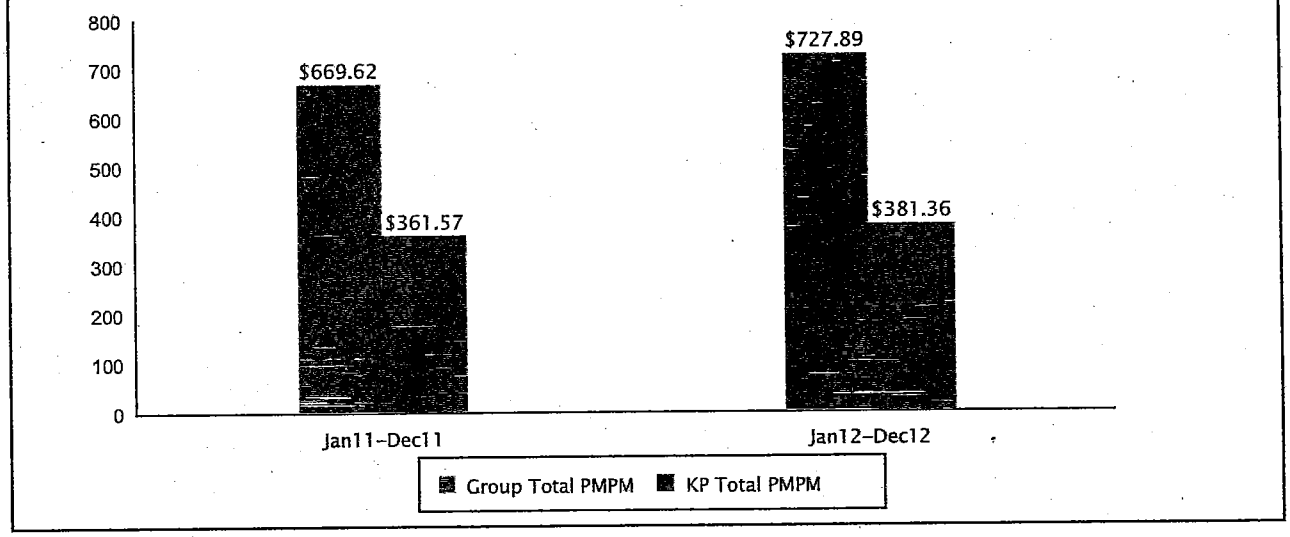
Total – $ PMPM

Group Name: HEALTH SERVICE SYSTEM (CITY AND COUNTY OF SF)
Group Number(s): 888
Subgroup(s): 0001,7001

Region: Northern California
Contract Period: 01/01/2014 - 12/31/2014

	Jan11 – Dec11	Jan12 – Dec12
Average Members*:	4,670	4,605

Total $ PMPM



Total $ PMPM *

Service Category	Jan11 – Dec11	Change	Jan12 – Dec12
Inpatient	$315.09	(5.4)%	$297.97
Outpatient	210.68	2.4%	215.75
Pharmacy	77.74	7.5%	83.56
Other	66.12	97.5%	130.60
Total $ PMPM	**$669.62**	**8.7%**	**$727.89**
Group to Health Plan Ratio	185.2%	3.1%	190.9%

* Includes Actives and/or pre 65 Retirees only.

Rate Buildup

Group Name: HEALTH SERVICE SYSTEM (CITY AND COUNTY OF SF)
Group Number(s): 888
Subgroup(s): 0001,7001

Product Type: HMO

Region: Northern California
Contract Period: 01/01/2014 - 12/31/2014
Report Period: Jan 2012 through Dec 2012

	Jan11 - Dec11	Jan12-Dec12
Average Members:	4,670	4,605

Rating Month: February 2013
Rating Members: 4,476

	Medical Calculation		Weight	Factor	Total$	PMPM$
A	**Projected Claims Calculation**					
A1	Paid Claims				$40,223,093	$727.888
A2	- Pooling Credit	Pooling Point:$550,000			(444,604)	(8.046)
A3	+ Pooling Charge				383,504	6.940
A4	Claims Net of Pooling				$40,161,993	$726.782
A5	X Incurred Claims Adjustment			0.99936		
A6	X Demographic Change			0.99390		
A7	X Historical Benefit Change			0.997800		
A8	Adjusted Claims					$720.297
A9	X Trend Factor	Annual Trend: 6.18%		1.12748		
A10	Claims based PMPM	24.0 Months Midpoint to Midpoint				$812.121
A11	Credibility		100%			

	Total Rate Calculation	Factor	Mo. Prem.	PMPM$
D	**Total Rate Calculation**			
D1	Blended Rate		$3,635,054	$812.121
D2	X Future Benefit Change	1.000000		
D3	Adjusted PMPM		$3,635,054	$812.121
D4	+ Retention		111,766	24.970
D5	+ Other Benefits		8,057	1.800
D6	+ Group Specific Charge		94,802	21.180
D7	+ Late Payment Charge		0	0.000
D8	+ Federal Health Insurer Fee		25,343	5.662
D9	+ Federal PCORI Fee/Transitional Reinsurance Program Contribution		24,260	5.420
D10	+ Premium Tax		0	0.000
D11	+ Commission		0	0.000
D12	**PMPM Premium Requirement**		**$3,899,281**	**$871.153**
E1	In-Force Rate		$3,665,383	$818.897
E2	**Quoted Rate PMPM before Underwriter Adjustment**	**6.38%**	**3,899,272**	**871.151**
E3	X Underwriter Adjustment	1.00187		
E4	**Quoted Rate PMPM after Underwriter Adjustment**	**6.58%**	**3,906,590**	**872.786**

Membership – Age and Gender Demographics

Group Name: HEALTH SERVICE SYSTEM (CITY AND COUNTY OF SF)

Region: Northern California

Group Number(s): 888

Contract Period: 01/01/2014-12/31/2014

Subgroup(s): 0001,7001

4377

Members*

	Average Jan11-Dec11				Average Jan12-Dec12				Current as of Feb13			
Age	Male	Female	Total	Percent	Male	Female	Total	Percent	Male	Female	Total	Percent
0-0	1	2	3	0.1%	1	1	1	0.0%	1	0	1	0.0%
1-4	7	6	13	0.3%	6	8	14	0.3%	5	9	14	0.3%
5-9	7	18	26	0.5%	6	19	25	0.5%	7	18	25	0.6%
10-14	33	36	69	1.5%	29	32	61	1.3%	29	34	63	1.4%
15-19	85	89	174	3.7%	86	78	164	3.6%	91	69	160	3.6%
20-24	139	148	287	6.1%	146	163	309	6.7%	146	170	316	7.1%
25-29	11	18	28	0.6%	37	39	76	1.7%	43	32	75	1.7%
30-34	2	8	10	0.2%	1	7	8	0.2%	1	5	6	0.1%
35-39	4	19	23	0.5%	4	17	21	0.5%	4	17	21	0.5%
40-44	7	26	33	0.7%	8	29	36	0.8%	8	34	42	0.9%
45-49	12	87	99	2.1%	10	71	81	1.8%	8	71	79	1.8%
50-54	152	276	428	9.2%	143	271	414	9.0%	130	264	394	8.8%
55-59	457	624	1,082	23.2%	450	643	1,094	23.7%	450	635	1,085	24.2%
60-64	1,105	1,287	2,392	51.2%	1,049	1,239	2,287	49.7%	1,001	1,188	2,189	48.9%
65-69	2	1	3	0.1%	6	8	14	0.3%	5	2	7	0.2%
70-74	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%
75-79	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%
80-84	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%
85+	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%
Total Members	2,025	2,645	4,670	100.0%	1,981	2,624	4,605	100.0%	1,929	2,548	4,477	100.0%
Percentage	43.4%	56.6%			43.0%	57.0%			43.1%	56.9%		

Health Plan Average Age:	33.8	34.6	34.2		33.8	34.6	34.2		33.8	34.6	34.2	
Group Average Age:	54.1	53.9	54.0		53.6	53.6	53.6		53.2	53.5	53.3	
Average Contract Size:			1.68				1.71				1.72	
Demographic Factor:**							1.70907				1.69864	%Change (0.6)%

Demographic Change: Current Demo Factor / Exp.Pd Demo Factor = 1.69864 / 1.70907 = 0.99390

* Includes Actives and /or pre 65 Retirees only.

** Each group's Demographic factor is calculated based on its own demographics compared to that of its Market Segment, not based on a comparison with the Health Plan.

Overview of Utilization

Group Name: HEALTH SERVICE SYSTEM (CITY AND COUNTY OF SF)

Group Number(s): 888

Subgroup(s): 0001,7001

Region: Northern California

Contract Period: 01/01/2014 - 12/31/2014

	Jan11 - Dec11	Jan12 - Dec12
Average Members*:	4,670	4,605

Inpatient Days/1000 *

Service Category	Jan11 - Dec11	Change	Jan12 - Dec12
Medical	180.3	6.7%	192.4
Surgical	161.5	(24.5)%	122.0
Maternity	1.7	52.9%	2.6
Mental Health	16.5	102.4%	33.4
Substance Abuse	7.5	(48.0)%	3.9
SNF	110.3	4.9%	115.7
Total Inpatient Days/1000	**477.7**	**(1.6)%**	**470.1**

Inpatient Admits/1000 *

Service Category	Jan11 - Dec11	Change	Jan12 - Dec12
Medical	42.0	(17.4)%	34.7
Surgical	30.8	(9.1)%	28.0
Maternity	0.9	44.4%	1.3
Mental Health	3.2	28.1%	4.1
Substance Abuse	1.1	36.4%	1.5
SNF	6.0	(6.7)%	5.6
Total Inpatient Admits/1000	**83.9**	**(10.1)%**	**75.4**

Outpatient Visits/1000 *

Service Category	Jan11 - Dec11	Change	Jan12 - Dec12
Outpatient Visits	5,840.2	5.6%	6,167.9
Emergency Room	187.1	0.5%	188.1
Surgical / Procedures	159.1	2.2%	162.6
Lab	5,034.6	1.3%	5,101.4
Radiology	1,205.1	(2.1)%	1,179.2
Total Outpatient Visits/1000	**12,426.1**	**3.0%**	**12,799.1**

Pharmacy Scripts PMPY *

Service Category	Jan11 - Dec11	Change	Jan12 - Dec12
Brand /Formulary	1.0	(10.0)%	0.9
Brand / Non-Formulary	0.3	0.0%	0.3
Generic / Formulary	9.6	(2.1)%	9.4
Generic / Non-Formulary	0.2	0.0%	0.2
Total Pharmacy Scripts PMPY	**11.1**	**(2.7)%**	**10.8**

* Includes actives and /or pre 65 Retirees Only.

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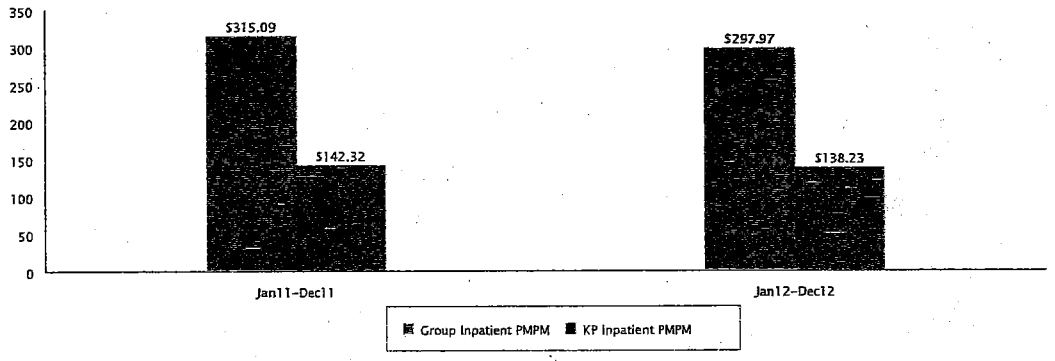
Inpatient – $ PMPM and $/Day

Group Name: HEALTH SERVICE SYSTEM (CITY AND COUNTY OF SF)
Region: Northern California
Group Number(s): 888
Contract Period: 01/01/2014 – 12/31/2014
Subgroup(s): 0001,7001

	Jan11 – Dec11	Jan12 – Dec12
Average Members*:	4,670	4,605

Inpatient $ PMPM



Inpatient $ PMPM *

Service Category	Jan11 – Dec11	Change	Jan12 – Dec12
Medical			
Hospital Medical	$99.14	1.6%	$100.73
Professional Medical	16.25	(2.2)%	15.90
Surgical			
Hospital Surgical	165.01	(13.9)%	142.00
Professional Surgical	24.98	(5.8)%	23.53
Maternity			
Hospital Maternity	0.69	56.5%	1.08
Professional Maternity	0.31	38.7%	0.43
Mental Health	2.71	56.5%	4.24
Substance Abuse	2.10	21.0%	2.54
SNF	3.89	93.1%	7.51
Total Inpatient $ PMPM	**$315.09**	**(5.4)%**	**$297.97**
Group to Health Plan Ratio	221.4%	(2.6)%	215.6%

Inpatient $/Day *

Service Category	Jan11 – Dec11	Change	Jan12 – Dec12
Medical			
Hospital Medical	$6,598.46	(4.8)%	$6,282.78
Professional Medical	1,081.32	(8.3)%	991.83
Surgical			
Hospital Surgical	12,264.55	13.8%	13,962.59
Professional Surgical	1,856.86	24.6%	2,313.58
Maternity			
Hospital Maternity	4,830.92	3.4%	4,996.38
Professional Maternity	2,192.88	(9.0)%	1,996.34
Mental Health	1,973.68	(22.9)%	1,521.54
Substance Abuse	3,356.88	132.3%	7,797.75
SNF	423.55	83.8%	778.50
Total Inpatient $/Day	**$7,914.70**	**(3.9)%**	**$7,605.56**

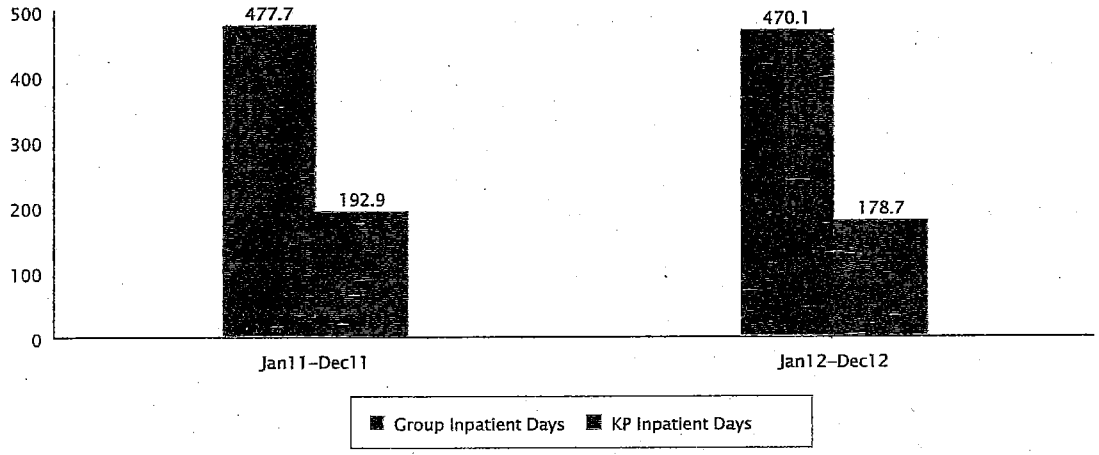
* Includes Actives and /or pre 65 Retirees only.

Inpatient – Days/1000 and ALOS

Group Name: HEALTH SERVICE SYSTEM (CITY AND COUNTY OF SF)
Region: Northern California
Group Number(s): 888
Contract Period: 01/01/2014 – 12/31/2014
Subgroup(s): 0001,7001

	Jan11 – Dec11	Jan12 – Dec12
Average Members*:	4,670	4,605

Inpatient Days/1000



Inpatient Days/1000 *

Service Category	Jan11 – Dec11	Change	Jan12 – Dec12
Medical	180.3	6.7%	192.4
Surgical	161.5	(24.5)%	122.0
Maternity	1.7	52.9%	2.6
Mental Health	16.5	102.4%	33.4
Substance Abuse	7.5	(48.0)%	3.9
SNF	110.3	4.9%	115.7
Total Inpatient Days/1000	**477.7**	**(1.6)%**	**470.1**

Inpatient ALOS *

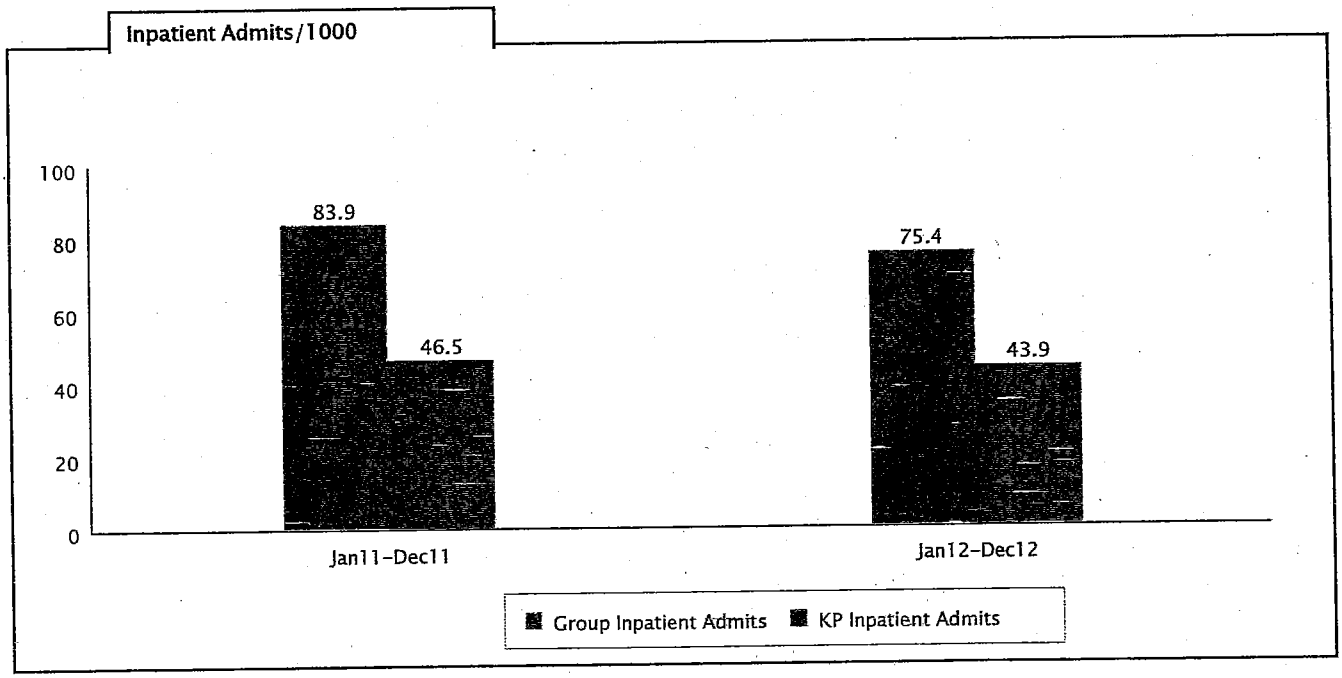
Service Category	Jan11 – Dec11	Change	Jan12 – Dec12
Medical	4.3	27.9%	5.5
Surgical	5.2	(15.4)%	4.4
Maternity	2.0	0.0%	2.0
Mental Health	5.1	58.8%	8.1
Substance Abuse	7.0	(62.9)%	2.6
SNF	18.4	11.4%	20.5
Total Inpatient ALOS	**5.7**	**8.8%**	**6.2**

* Includes Actives and /or pre 65 Retirees only.

Inpatient – Admits/1000

Group Name: HEALTH SERVICE SYSTEM (CITY AND COUNTY OF SF)
Region: Northern California
Group Number(s): 888
Contract Period: 01/01/2014 – 12/31/2014
Subgroup(s): 0001,7001

	Jan11 – Dec11	Jan12 – Dec12
Average Members*:	4,670	4,605



Inpatient Admits/1000 *

Service Category	Jan11 – Dec11	Change	Jan12 – Dec12
Medical	42.0	(17.4)%	34.7
Surgical	30.8	(9.1)%	28.0
Maternity	0.9	44.4%	1.3
Mental Health	3.2	28.1%	4.1
Substance Abuse	1.1	36.4%	1.5
SNF	6.0	(6.7)%	5.6
Total Inpatient Admits/1000	**83.9**	**(10.1)%**	**75.4**

* Includes Actives and /or pre 65 Retirees only.

Inpatient Claims Top 25 DRG – Comparison to Health Plan

Non – Medicare

Region: Northern California

Group Name: HEALTH SERVICE SYSTEM (CITY AND COUNTY OF SF)

Group Numbers: 888

Subgroups: 0001,7001

Contract Period: 01/01/2014 – 12/31/2014

Jan12 – Dec12

Average Members *: 4,605

			Group							Health Plan						
			Admits				Claims			Admits				Claims		
DRG	DRG Label	Category	Count	per 1,000	Days	ALOS	Total Inpatient	PMPM	per Admit	Count	per 1,000	Days	ALOS	Total Inpatient	PMPM	per Admit
Volume																
576	SEPTICEMIA W/O MV 96+ HOURS W/ OR W/O MCC	MED	24	5.2	167	7.0	$1,414,479	$25.60	$58,936.63	3,293	1.5	14,334	4.4	$133,371,495	$5.13	$40,501.52
544	MAJOR JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY	SURG	21	4.6	51	2.4	1,138,389	20.60	54,209.01	2,972	1.4	7,272	2.4	162,161,821	6.24	54,563.20
430	PSYCHOSES	MH	15	3.3	128	8.5	202,350	3.66	13,489.99	3,971	1.8	23,488	5.9	37,367,393	1.44	9,410.07
247	PERCUTANEOUS CARDIOVASC PROC W DRUG-ELUTING STENT OR 4+ VES/STENTS W MCC	SURG	9	2.0	17	1.9	471,384	8.53	52,376.01	944	0.4	1,774	1.9	53,733,008	2.07	56,920.56
316	RENAL FAILURE	MED	9	2.0	53	5.9	377,230	6.83	41,914.40	610	0.3	2,460	4.0	24,217,462	0.93	39,700.76
410	CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS	MED	7	1.5	32	4.6	270,374	4.89	38,624.81	442	0.2	2,049	4.6	17,881,362	0.69	40,455.57
521	ALCOHOL/DRUG ABUSE OR DEPENDENCE W CC	SUB AB	7	1.5	18	2.6	140,360	2.54	20,051.36	234	0.1	884	3.8	4,559,439	0.18	19,484.78
014	INTRACRANIAL HEMORRHAGE & STROKE W INFARCT	MED	6	1.3	30	5.0	281,058	5.09	46,842.97	956	0.4	3,835	4.0	37,207,327	1.43	38,919.80
462	REHABILITATION	MED	5	1.1	98	19.6	370,487	6.70	74,097.40	475	0.2	7,947	16.7	32,169,634	1.24	67,725.55
470	UNGROUPABLE	MED	5	1.1	17	3.4	161,577	2.92	32,315.30	1,145	0.5	6,060	5.3	49,860,719	1.92	43,546.48
127	HEART FAILURE & SHOCK	MED	5	1.1	9	1.8	79,523	1.44	15,904.68	675	0.3	2,722	4.0	22,412,584	0.86	33,203.83
373	VAGINAL DELIVERY W/O COMPLICATING DIAGNOSES	MAT	5	1.1	11	2.2	75,791	1.37	15,158.12	14,649	6.8	28,695	2.0	198,888,432	7.65	13,576.93

Inpatient Claims Top 25 DRG – Comparison to Health Plan

Non – Medicare

Region: Northern California

Group Name: HEALTH SERVICE SYSTEM (CITY AND COUNTY OF SF)

Contract Period: 01/01/2014 – 12/31/2014

Group Numbers: 888

Subgroups: 0001,7001

Jan12 – Dec12

Average Members *: 4,605

			Group							Health Plan						
			Admits				Claims			Admits				Claims		
DRG	DRG Label	Category	Count	per 1,000	Days	ALOS	Total Inpatient	PMPM	per Admit	Count	per 1,000	Days	ALOS	Total Inpatient	PMPM	per Admit
Volume																
570	MAJOR SMALL & LARGE BOWEL PROCEDURES W/O CC, MCC	SURG	4	0.9	75	18.8	755,862	13.68	188,965.48	246	0.1	1,819	7.4	19,649,205	0.76	79,874.82
076	OTHER RESP SYSTEM OR PROCEDURES W CC	SURG	4	0.9	15	3.8	240,572	4.35	60,142.99	92	0.0	521	5.7	6,597,242	0.25	71,709.15
483	LAPAROSCOPIC CHOLECYSTECTOMY W/O CDE W CC	SURG	4	0.9	12	3.0	157,392	2.85	39,347.88	487	0.2	1,628	3.3	21,028,324	0.81	43,179.31
160	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL WITHOUT MCC	SURG	4	0.9	7	1.8	111,910	2.03	27,977.40	86	0.0	204	2.4	2,695,333	0.10	31,341.08
188	OTHER DIGESTIVE SYSTEM DIAGNOSES WITH MCC	MED	4	0.9	14	3.5	108,203	1.96	27,050.68	185	0.1	711	3.8	5,651,872	0.22	30,550.66
138	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W MCC	MED	4	0.9	11	2.8	85,916	1.55	21,479.03	406	0.2	1,105	2.7	9,537,311	0.37	23,490.91
182	ESOPHAGITIS GASTROENT & MISC DIGEST DISORDERS WITH MCC	MED	4	0.9	5	1.3	40,827	0.74	10,206.81	621	0.3	2,107	3.4	15,202,447	0.58	24,480.59
426	DEPRESSIVE NEUROSES	MH	4	0.9	26	6.5	31,967	0.58	7,991.83	506	0.2	1,638	3.2	2,436,433	0.09	4,815.08
470	UNGROUPABLE	SURG	3	0.7	27	9.0	344,980	6.24	114,993.27	455	0.2	2,469	5.4	34,306,639	1.32	75,399.21
174	GI HEMORRHAGE W CC	MED	3	0.7	36	12.0	273,961	4.96	91,320.39	560	0.3	1,645	2.9	15,562,329	0.60	27,789.87
578	INFECTIOUS & PARASITIC DISEASES W O.R. PROCEDURE W/ OR W/O CC/ MCC	SURG	3	0.7	16	5.3	211,495	3.83	70,498.27	437	0.2	4,730	10.8	56,815,200	2.19	130,011.90

Inpatient Claims Top 25 DRG – Comparison to Health Plan

Non – Medicare

Region: Northern California

Group Name: HEALTH SERVICE SYSTEM (CITY AND COUNTY OF SF)

Contract Period: 01/01/2014 – 12/31/2014

Group Numbers: 888

Subgroups: 0001,7001

Jan12 – Dec12

Average Members *: 4,605

			Group							Health Plan						
			Admits				Claims			Admits				Claims		
DRG	DRG Label	Category	Count	per 1,000	Days	ALOS	Total Inpatient	PMPM	per Admit	Count	per 1,000	Days	ALOS	Total Inpatient	PMPM	per Admit
Volume																
285	AMPUTAT OF LOWER LIMB FOR ENDOCRINE NUTRIT & METAB DISORDERS	SURG	3	0.7	9	3.0	149,262	2.70	49,754.00	96	0.0	505	5.3	5,203,440	0.20	54,202.50
180	GI OBSTRUCTION W CC	MED	3	0.7	19	6.3	109,410	1.98	36,470.00	354	0.2	1,393	3.9	9,779,918	0.38	27,626.89
	Top DRG: MATERNITY		5	1.1	11	2.2	75,791	1.37	15,158.12	14,649	6.8	28,695	2.0	198,888,432	7.65	13,576.93
	% of Total Inpatient		1.4%		0.5%			0.5%		15.4%		7.4%			5.5%	
	Top DRG: MEDICAL		79	17.2	491	6.2	3,573,044	64.66	45,228.41	9,722	4.5	46,368	4.8	372,854,461	14.34	38,351.62
	% of Total Inpatient		22.8%		22.7%			21.7%		10.2%		12.0%			10.4%	
	Top DRG: MENTAL HEALTH		19	4.1	154	8.1	234,317	4.24	12,332.48	4,477	2.1	25,126	5.6	39,803,826	1.53	8,890.74
	% of Total Inpatient		5.5%		7.1%			1.4%		4.7%		6.5%			1.1%	
	Top DRG: SUBSTANCE ABUSE		7	1.5	18	2.6	140,360	2.54	20,051.36	234	0.1	884	3.8	4,559,439	0.18	19,484.78
	% of Total Inpatient		2.0%		0.8%			0.9%		0.2%		0.2%			0.1%	
	Top DRG: SURGICAL		55	11.9	229	4.2	3,581,245	64.81	65,113.54	5,815	2.7	20,922	3.6	362,190,213	13.93	62,285.51
	% of Total Inpatient		15.9%		10.6%			21.7%		6.1%		5.4%			10.1%	
	All Other DRG		182	39.6	1,262	6.9	8,861,285	160.36	48,688.38	60,170	27.8	265,186	4.4	2,615,011,854	100.60	43,460.39
			52.4%		58.3%			53.8%		63.3%		68.5%			72.8%	
Total Inpatient			347	75.4	2,165	6.2	$16,466,042	$297.97	$47,452.57	95,067	43.9	387,181	4.1	$3,593,308,224	$138.23	$37,797.64

* Includes actives and / or pre 65 Retirees Only

Inpatient Claims Top 25 DRG – Two-Year Comparison

Region: Northern California

Contract Period: 01/01/2014 – 12/31/2014

Group Name: HEALTH SERVICE SYSTEM (CITY AND COUNTY OF SF)

Group Numbers: 888

Subgroups: 0001,7001

	Jan11 – Dec11	Jan12 – Dec12
Average Members *:	4,670	4,605

DRG	DRG Label	Category	Admits Jan11 – Dec11 Count	Admits Jan11 – Dec11 per 1,000	Days	ALOS	Claims Jan11 – Dec11 Total Inpatient	Claims Jan11 – Dec11 PMPM	Claims Jan11 – Dec11 per Admit	Admits Jan12 – Dec12 Count	Admits Jan12 – Dec12 per 1,000	Day	ALOS	Claims Jan12 – Dec12 Total Inpatient	Claims Jan12 – Dec12 PMPM	Claims Jan12 – Dec12 per Admit
Volume																
576	SEPTICEMIA W/O MV 96+ HOURS W/ OR W/O MCC	MED	12	2.6	57	4.8	$523,318	$9.34	$43,609.84	24	5.2	167	7.0	$1,414,479	$25.60	$58,936.63
544	MAJOR JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY	SURG	24	5.1	62	2.6	1,308,148	23.34	54,506.18	21	4.6	51	2.4	1,138,389	20.60	54,209.01
430	PSYCHOSES	MH	9	1.9	56	6.2	100,654	1.80	11,183.83	15	3.3	128	8.5	202,350	3.66	13,489.99
557	PERCUTANEOUS CARDIOVASC PROC W DRUG-ELUTING STENT OR 4+ VES/STENTS W MCC	SURG	7	1.5	13	1.9	352,785	6.30	50,397.83	9	2.0	17	1.9	471,384	8.53	52,376.01
316	RENAL FAILURE	MED	7	1.5	18	2.6	149,688	2.67	21,383.94	9	2.0	53	5.9	377,230	6.83	41,914.40
410	CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS	MED	3	0.6	14	4.7	111,975	2.00	37,325.00	7	1.5	32	4.6	270,374	4.89	38,624.81
521	ALCOHOL/DRUG ABUSE OR DEPENDENCE W CC	SUB AB	3	0.6	15	5.0	93,209	1.66	31,069.78	7	1.5	18	2.6	140,360	2.54	20,051.36
014	INTRACRANIAL HEMORRHAGE & STROKE W INFARCT	MED	6	1.3	34	5.7	285,734	5.10	47,622.35	6	1.3	30	5.0	281,058	5.09	46,842.97
462	REHABILITATION	MED	4	0.9	80	20.0	282,905	5.05	70,726.20	5	1.1	98	19.6	370,487	6.70	74,097.40
470	UNGROUPABLE	MED	4	0.9	11	2.8	90,706	1.62	22,676.48	5	1.1	17	3.4	161,577	2.92	32,315.30
127	HEART FAILURE & SHOCK	MED	8	1.7	60	7.5	326,884	5.83	40,860.55	5	1.1	9	1.8	79,523	1.44	15,904.68
373	VAGINAL DELIVERY W/O COMPLICATING DIAGNOSES	MAT	3	0.6	6	2.0	42,146	0.75	14,048.80	5	1.1	11	2.2	75,791	1.37	15,158.12

4385

Created On: 4/9/2013

NPS RQR Number: 6427167

SPAS RQR Number/Set ID: 393288-10400-278-1

NPS RQR Name: HSS Early Retirees

Non – Medicare

Inpatient Claims Top 25 DRG – Two-Year Comparison

Region: Northern California

Contract Period: 01/01/2014 – 12/31/2014

Group Name: HEALTH SERVICE SYSTEM (CITY AND COUNTY OF SF)

Group Numbers: 888

Subgroups: 0001,7001

	Jan11 – Dec11	Jan12 – Dec12
Average Members *:	4,670	4,605

DRG	DRG Label	Category	Admits Count	Admits per 1,000	Admits Days	Admits ALOS	Claims Total Inpatient	Claims PMPM	Claims per Admit	Admits Count	Admits per 1,000	Admits Day	Admits ALOS	Claims Total Inpatient	Claims PMPM	Claims per Admit
Volume							Jan11 – Dec11							Jan12 – Dec12		
570	MAJOR SMALL & LARGE BOWEL PROCEDURES W/O CC, MCC	SURG	4	0.9	109	27.3	975,278	17.40	243,819.61	4	0.9	75	18.8	755,862	13.68	188,965.48
076	OTHER RESP SYSTEM OR PROCEDURES W CC	SURG	1	0.2	12	12.0	117,832	2.10	117,831.95	4	0.9	15	3.8	240,572	4.35	60,142.99
493	LAPAROSCOPIC CHOLECYSTECTOMY W/O CDE W CC	SURG	6	1.3	29	4.8	322,532	$5.76	$53,755.31	4	0.9	12	3.0	157,392	2.85	$39,347.88
160	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL WITHOUT MCC	SURG	1	0.2	2	2.0	26,961	0.48	26,960.60	4	0.9	7	1.8	111,910	2.03	27,977.40
188	OTHER DIGESTIVE SYSTEM DIAGNOSES WITH MCC	MED	1	0.2	2	2.0	16,102	0.29	16,101.50	4	0.9	14	3.5	108,203	1.96	27,050.68
138	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W MCC	MED	6	1.3	15	2.5	122,532	2.19	20,422.00	4	0.9	11	2.8	85,916	1.55	21,479.03
182	ESOPHAGITIS GASTROENT & MISC DIGEST DISORDERS WITH MCC	MED	6	1.3	20	3.3	141,890	2.53	23,648.30	4	0.9	5	1.3	40,827	0.74	10,206.81
426	DEPRESSIVE NEUROSES	MH	2	0.4	6	3.0	18,116	0.32	9,057.79	4	0.9	26	6.5	31,967	0.58	7,991.83
470	UNGROUPABLE	SURG	3	0.6	8	2.7	188,554	3.36	62,851.27	3	0.7	27	9.0	344,980	6.24	114,993.27
174	GI HEMORRHAGE W CC	MED	4	0.9	10	2.5	97,684	1.74	24,421.00	3	0.7	36	12.0	273,961	4.96	91,320.39
578	INFECTIOUS & PARASITIC DISEASES W O.R. PROCEDURE W/ OR W/O CC/ MCC	SURG	3	0.6	35	11.7	399,988	7.14	133,329.32	3	0.7	16	5.3	211,495	3.83	70,498.27

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Created On: 4/9/2013

NPS RQR Number: 6427167

SPAS RQR Number/Set ID: 393288-10400-278-1

NPS RQR Name: HSS Early Retirees

Non – Medicare

Inpatient Claims Top 25 DRG – Two-Year Comparison

Region: Northern California

Contract Period: 01/01/2014 – 12/31/2014

Group Name: HEALTH SERVICE SYSTEM (CITY AND COUNTY OF SF)

Group Numbers: 888

Subgroups: 0001,7001

	Jan11 – Dec11	Jan12 – Dec12
Average Members *:	4,670	4,605

DRG	DRG Label	Category	Admits Jan11 – Dec11 Count	Admits Jan11 – Dec11 per 1,000	Admits Jan11 – Dec11 Days	Admits Jan11 – Dec11 ALOS	Claims Jan11 – Dec11 Total Inpatient	Claims Jan11 – Dec11 PMPM	Claims Jan11 – Dec11 per Admit	Admits Jan12 – Dec12 Count	Admits Jan12 – Dec12 per 1,000	Admits Jan12 – Dec12 Day	Admits Jan12 – Dec12 ALOS	Claims Jan12 – Dec12 Total Inpatient	Claims Jan12 – Dec12 PMPM	Claims Jan12 – Dec12 per Admit
Volume																
285	AMPUTAT OF LOWER LIMB FOR ENDOCRINE NUTRIT & METAB DISORDERS	SURG	1	0.2	5	5.0	48,960	0.87	48,960.10	3	0.7	9	3.0	149,262	2.70	49,754.00
180	GI OBSTRUCTION W CC	MED	1	0.2	3	3.0	23,580	0.42	23,580.00	3	0.7	19	6.3	109,410	1.98	36,470.00
	Top DRG: MATERNITY		3	0.6	6	2.0	42,146	0.75	14,048.80	5	1.1	11	2.2	75,791	1.37	15,158.12
	% of Total Inpatient		0.8%		0.3%			0.2%		1.4%		0.5%			0.5%	
	Top DRG: MEDICAL		62	13.3	324	5.2	2,172,997	38.78	35,048.34	79	17.2	491	6.2	3,573,044	64.66	45,228.41
	% of Total Inpatient		15.8%		14.5%			12.3%		22.8%		22.7%			21.7%	
	Top DRG: MENTAL HEALTH		11	2.4	62	5.6	118,770	2.12	10,797.27	19	4.1	154	8.1	234,317	4.24	12,332.48
	% of Total Inpatient		2.8%		2.8%			0.7%		5.5%		7.1%			1.4%	
	Top DRG: SUBSTANCE ABUSE		3	0.6	15	5.0	93,209	$1.66	$31,069.78	7	1.5	18	2.6	140,360	2.54	$20,051.36
	% of Total Inpatient		0.8%		0.7%			0.5%		2.0%		0.8%			0.9%	
	Top DRG: SURGICAL		50	10.7	275	5.5	3,741,038	66.76	74,820.76	55	11.9	229	4.2	3,581,245	64.81	65,113.54
	% of Total Inpatient		12.8%		12.3%			21.2%		15.9%		10.6%			21.7%	
	All Other DRG		263	56.3	1,549	5.9	11,489,541	205.02	43,686.47	182	39.6	1,262	6.9	8,861,285	160.36	48,688.38
			67.1%		69.4%			65.1%		52.4%		58.3%			53.8%	
	Total Inpatient		392	83.9	2,231	5.7	$17,657,701	$315.09	$45,045.16	347	75.4	2,165	6.2	$16,466,042	$297.97	$47,452.57

* Includes actives and /or pre 65 Retirees Only.

4387

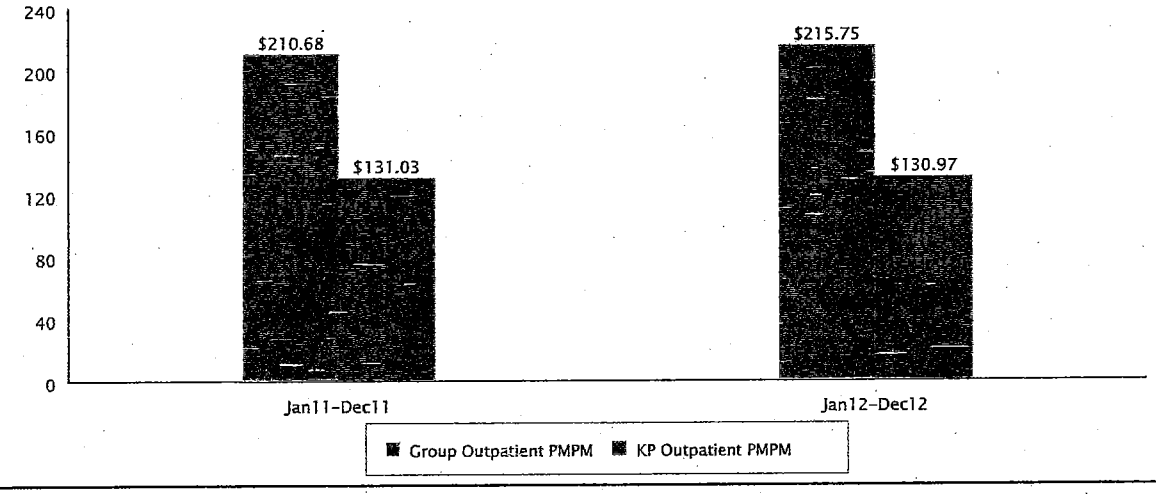
Outpatient – $ PMPM and $/Visit

Group Name: HEALTH SERVICE SYSTEM (CITY AND COUNTY OF SF)
Group Number(s): 888
Subgroup(s): 0001,7001

Region: Northern California
Contract Period: 01/01/2014 – 12/31/2014

	Jan11 – Dec11	Jan12 – Dec12
Average Members*:	4,670	4,605

Outpatient $ PMPM



Outpatient $ PMPM *

Service Category	Jan11 – Dec11	Change	Jan12 – Dec12
Outpatient Visits	$80.95	6.9%	$86.54
Emergency Room	17.82	17.9%	21.01
Surgical/Procedures			
Outpatient Surgery Facility	39.94	16.7%	46.60
Outpatient Surgery Professional	15.31	(2.7)%	14.90
Lab	20.68	(9.8)%	18.65
Radiology	35.98	(22.0)%	28.05
Total Outpatient $ PMPM	**$210.68**	**2.4%**	**$215.75**
Group to Health Plan Ratio	160.8%	2.4%	164.7%

Outpatient $/Visit *

Service Category	Jan11 – Dec11	Change	Jan12 – Dec12
Outpatient Visits	$166.34	1.2%	$168.37
Emergency Room	1,142.65	17.3%	1,340.57
Surgical/Procedures			
Outpatient Surgery Facility	3,012.31	14.1%	3,438.34
Outpatient Surgery Professional	1,154.39	(4.8)%	1,099.04
Lab	49.29	(11.0)%	43.87
Radiology	358.29	(20.3)%	285.47
Total Outpatient $/Visit	**$203.45**	**(0.6)%**	**$202.28**

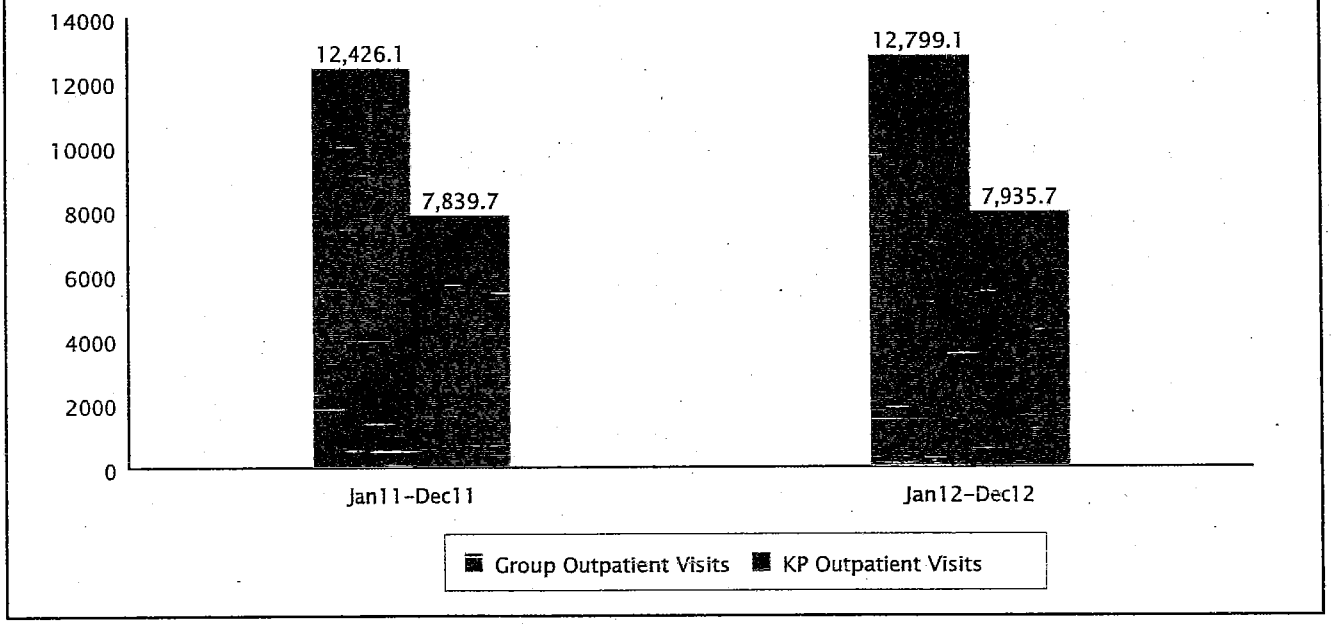
* Includes Actives and /or pre 65 Retirees only.

Outpatient – Visits/1000

Group Name: HEALTH SERVICE SYSTEM (CITY AND COUNTY OF SF)
Region: Northern California
Group Number(s): 888
Contract Period: 01/01/2014–12/31/2014
Subgroup(s): 0001,7001

	Jan11 – Dec11	Jan12 – Dec12
Average Members*:	4,670	4,605

Outpatient Visits/1000



Outpatient Visits/1000 *

Service Category	Jan11 – Dec11	Change	Jan12 – Dec12
Outpatient Visits	5,840.2	5.6%	6,167.9
Emergency Room	187.1	0.5%	188.1
Surgical/Procedures	159.1	2.2%	162.6
Lab	5,034.6	1.3%	5,101.4
Radiology	1,205.1	(2.1)%	1,179.2
Total Outpatient Visits/1000	**12,426.1**	**3.0%**	**12,799.1**

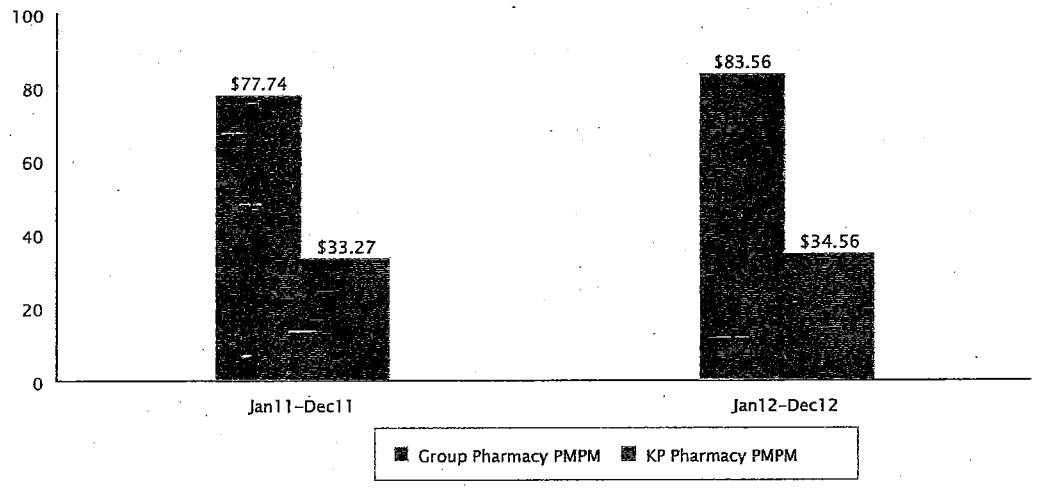
* Includes Actives and /or pre 65 Retirees only.

Pharmacy – $ PMPM and $/Script

Group Name: HEALTH SERVICE SYSTEM (CITY AND COUNTY OF SF)
Region: Northern California
Group Number(s): 888
Contract Period: 01/01/2014-12/31/2014
Subgroup(s): 0001,7001

	Jan11 – Dec11	Jan12 – Dec12
Average Members*:	4,670	4,605

Pharmacy $ PMPM



Pharmacy $ PMPM *

Service Category	Jan11 – Dec11	Change	Jan12 – Dec12
Brand /Formulary	$45.70	11.0%	$50.72
Brand/Non-Formulary	9.60	(1.3)%	9.48
Generic/Formulary	21.12	4.0%	21.97
Generic/Non-Formulary	1.32	5.3%	1.39
Total Pharmacy $ PMPM	**$77.74**	**7.5%**	**$83.56**
Group to Health Plan Ratio	233.7%	3.5%	241.8%

Pharmacy $/Script *

Service Category	Jan11 – Dec11	Change	Jan12 – Dec12
Brand /Formulary	$527.65	24.4%	$656.55
Brand/Non-Formulary	374.62	12.3%	420.82
Generic/Formulary	26.46	5.7%	27.98
Generic/Non-Formulary	71.13	8.2%	76.96
Total Pharmacy $/Script	**$83.68**	**10.6%**	**$92.54**

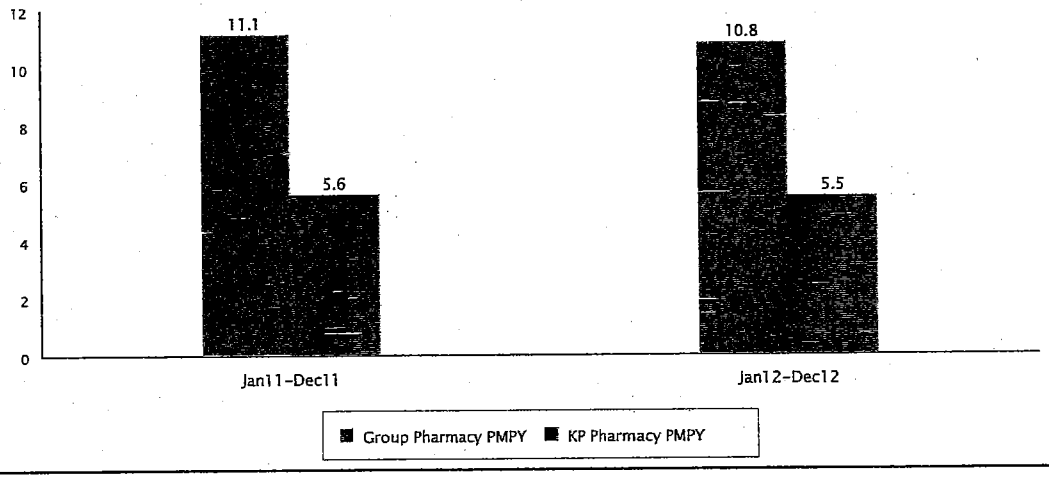
* Includes Actives and /or pre 65 Retirees only.

Pharmacy – Scripts / PMPY

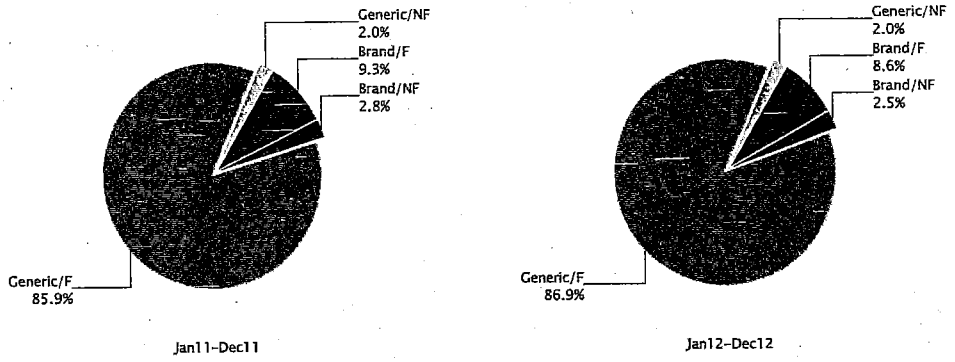
Group Name: HEALTH SERVICE SYSTEM (CITY AND COUNTY OF SF)
Region: Northern California
Group Number(s): 888
Contract Period: 01/01/2014–12/31/2014
Subgroup(s): 0001,7001

	Jan11 – Dec11	Jan12 – Dec12
Average Members*:	4,670	4,605

Pharmacy Scripts PMPY



Pharmacy Scripts Comparison



Pharmacy Scripts PMPY *

Service Category	Jan11 – Dec11	Change	Jan12 – Dec12
Brand /Formulary (F)	1.0	(10.0)%	0.9
Brand/Non-Formulary (NF)	0.3	0.0%	0.3
Generic/Formulary (F)	9.6	(2.1)%	9.4
Generic/Non-Formulary (NF)	0.2	0.0%	0.2
Total Pharmacy Scripts PMPY	11.1	(2.7)%	10.8

* Includes Actives and /or pre 65 Retirees only.

Pharmacy Detail

Group Name: HEALTH SERVICE SYSTEM (CITY AND COUNTY OF SF)

Group Number(s): 888

Subgroup(s): 0001,7001

Region: Northern California

Contract Period: 01/01/2014-12/31/2014

	Jan12 - Dec12
Average Members *:	4,605

	GENERIC						BRAND						TOTAL					
	$ Claims	% of Total Rx Claims	PMPM Claims	Scripts	% of Total Scripts	$ per Script	$ Claims	% of Total Rx Claims	PMPM Claims	Scripts	% of Total Scripts	$ per Script	$ Claims	% of Total Rx Claims	PMPM Claims	Scripts	% of Total Scripts	$ per Script
Formulary	$1,214,124	26.3%	$21.97	43,385	86.9%	$27.98	$2,802,798	60.7%	$50.72	4,269	8.6%	$656.55	$4,016,923	87.0%	$72.69	47,654	95.5%	$84.29
Non-Formulary	76,810	1.7%	1.39	998	2.0%	76.96	523,918	11.3%	9.48	1,245	2.5%	420.82	600,728	13.0%	10.87	2,243	4.5%	267.82
Rx Total	**$1,290,935**	**28.0%**	**$23.36**	**44,383**	**88.9%**	**$29.09**	**$3,326,716**	**72.0%**	**$60.20**	**5,514**	**11.1%**	**$603.32**	**$4,617,651**	**100.0%**	**$83.56**	**49,897**	**100.0%**	**$92.54**

* Includes actives and /or pre 65 Retirees Only.

4392

Created on: 4/9/2013

SPAS RQR Number/Set ID: 393288-10400-278-1

NPS RQR Number: 6427167

NPS RQR Name: HSS Early Retirees

Non – Medicare

Top 25 Drugs by Total Scripts

Group Name: HEALTH SERVICE SYSTEM (CITY AND COUNTY OF SF)

Group Number: 888

Subgroups: 0001,7001

Region: Northern California

Contract Period: 01/01/2014 – 12/31/2014

Jan12 – Dec12

Average Members *: 4,605

Therapeutic Class	NDC	Drug Name	Brand/ Generic	Formulary /Non- For mulary	Annual Scripts per Member	Group Scripts	Group Rank	Group % of Total Scripts	Health Plan Rank	Health Plan % of Total Scripts
CARDIOVASCULAR THERAPY AGENTS	29300012810	HYDROCHLOROTHIAZIDE 25 MG TAB	G	F	0.24	1,094	1	2.2%	4	1.3 %
RESPIRATORY THERAPY AGENTS	60505085003	FLUTICASONE 50 MCG/ACTUATION SPSN	G	F	0.23	1,054	2	2.1%	1	2.6 %
RESPIRATORY THERAPY AGENTS	59310057920	PROAIR HFA 90 MCG/ACTUATION HFAA	B	F	0.19	890	3	1.8%	2	2.6 %
ANALGESIC, ANTI-INFLAMMATORY OR ANTIPYRETIC	00603388128	HYDROCODONE-ACETAMINOPHEN 5-500 MG TAB	G	F	0.16	737	4	1.5%	3	1.9 %
GASTROINTESTINAL THERAPY AGENTS	62175011843	OMEPRAZOLE 20 MG CPDR	G	F	0.16	716	5	1.4%	9	0.9 %
ENDOCRINE	65862000801	METFORMIN 500 MG TAB	G	F	0.15	698	6	1.4%	10	0.9 %
CARDIOVASCULAR THERAPY AGENTS	00093715510	SIMVASTATIN 40 MG TAB	G	F	0.15	684	7	1.4%	11	0.9 %
CARDIOVASCULAR THERAPY AGENTS	00093078710	ATENOLOL 25 MG TAB	G	F	0.13	604	8	1.2%	12	0.8 %
DRUGS TO TREAT ERECTILE DYFUNCTION	00173083113	LEVITRA 20 MG TAB	B	F	0.11	516	9	1.0%	16	0.7 %
CARDIOVASCULAR THERAPY AGENTS	00093075210	ATENOLOL 50 MG TAB	G	F	0.11	503	10	1.0%	21	0.6 %
CARDIOVASCULAR THERAPY AGENTS	00093715410	SIMVASTATIN 20 MG TAB	G	F	0.10	457	11	0.9%	18	0.6 %
RESPIRATORY THERAPY AGENTS	59310020480	QVAR 80 MCG/ACTUATION AERO	B	F	0.09	411	12	0.8%	6	1.1 %
CARDIOVASCULAR THERAPY AGENTS	59762153003	AMLODIPINE 5 MG TAB	G	F	0.09	408	13	0.8%	20	0.6 %
CARDIOVASCULAR THERAPY AGENTS	59762154003	AMLODIPINE 10 MG TAB	G	F	0.09	393	14	0.8%	35	0.4 %
CARDIOVASCULAR THERAPY AGENTS	68180051403	LISINOPRIL 10 MG TAB	G	F	0.08	376	15	0.8%	26	0.5 %

4393

Created On: 4/9/2013

NPS RQR Number: 6427167

SPAS RQR Number/Set ID: 393288-10400-278-1

NPS RQR Name: HSS Early Retirees

Non – Medicare

Top 25 Drugs by Total Scripts

Group Name: HEALTH SERVICE SYSTEM (CITY AND COUNTY OF SF)

Group Number: 888

Subgroups: 0001,7001

Region: Northern California

Contract Period: 01/01/2014 – 12/31/2014

	Jan12 – Dec12
Average Members *:	4,605

Therapeutic Class	NDC	Drug Name	Brand/ Generic	Formulary /Non- For mulary	Annual Scripts per Member	Group Scripts	Group Rank	Group % of Total Scripts	Health Plan Rank	Health Plan % of Total Scripts
CARDIOVASCULAR THERAPY AGENTS	00185007410	LOVASTATIN 40 MG TAB	G	F	0.08	373	16	0.7%	38	0.4 %
RESPIRATORY THERAPY AGENTS	00603107556	CHERATUSSIN AC 10-100 MG/5 ML LIQD	G	F	0.08	347	17	0.7%	14	0.7 %
ANALGESIC, ANTI-INFLAMMATORY OR ANTIPYRETIC	00406036701	HYDROCODONE-ACETAMINOPHEN 10-325 MG TAB	G	F	0.07	333	18	0.7%	8	0.9 %
ANALGESIC, ANTI-INFLAMMATORY OR ANTIPYRETIC	00406051201	OXYCODONE-ACETAMINOPHEN 5-325 MG TAB	G	F	0.07	320	19	0.6%	27	0.5 %
CARDIOVASCULAR THERAPY AGENTS	68180051503	LISINOPRIL 20 MG TAB	G	F	0.06	299	20	0.6%	34	0.4 %
ENDOCRINE	65862001001	METFORMIN 1,000 MG TAB	G	F	0.06	290	21	0.6%	28	0.5 %
CARDIOVASCULAR THERAPY AGENTS	68180051802	LISINOPRIL-HYDROCHLOROTHIAZIDE 10-12.5 MG TAB	G	F	0.06	288	22	0.6%	39	0.4 %
CARDIOVASCULAR THERAPY AGENTS	00093715610	SIMVASTATIN 80 MG TAB	G	F	0.06	287	23	0.6%	50	0.3 %
ENDOCRINE	00169183411	NOVOLIN N 100 UNIT/ML SUSP	B	F	0.06	283	24	0.6%	25	0.5 %
ANALGESIC, ANTI-INFLAMMATORY OR ANTIPYRETIC	00406036705	HYDROCODONE-ACETAMINOPHEN 10-325 MG TAB	G	F	0.06	280	25	0.6%	17	0.7 %
		ALL OTHER			8.09	37,256		74.7%		78.4 %
	TOTAL:				10.84	49,897		100.0 %		100.0 %

* Includes actives and /or pre 65 Retirees Only.

4394

Created On: 4/9/2013
NPS RQR Number: 6427167

SPAS RQR Number/Set ID: 393288-10400-278-1
NPS RQR Name: HSS Early Retirees

Top 25 Drugs by Net Claims

Group Name: HEALTH SERVICE SYSTEM (CITY AND COUNTY OF SF)

Group Number: 888

Subgroups: 0001,7001

Region: Northern California

Contract Period: 01/01/2014 – 12/31/2014

Average Members *: Jan12 – Dec12: 4,605

Therapeutic Class	NDC	Drug Name	Brand/ Generic	Formulary /Non- For mulary	% of Total Net Claims	Group Net Claims	Group Rank	Group Net Claims Per Script	Health Plan Rank	Health Plan Net Claims Per Script
ANTINEOPLASTICS	00078043815	GLEEVEC 400 MG TAB	B	F	4.6%	$211,474.30	1	$6,042.12	9	$6,541.84
ANTI-INFECTIVE AGENTS	61958070101	TRUVADA 200-300 MG TAB	B	F	3.3%	150,578.15	2	2,509.64	3	2,081.88
ANTINEOPLASTICS	59572041000	REVLIMID 10 MG CAP	B	F	2.3%	104,748.15	3	6,546.76	88	7,983.66
ANTI-INFECTIVE AGENTS	00003161112	BARACLUDE 0.5 MG TAB	B	F	2.2%	103,765.95	4	2,594.15	13	2,596.57
MULTIPLE SCLEROSIS AGENTS	68546031730	COPAXONE 20 MG KIT	B	F	2.2%	102,244.65	5	3,786.84	2	3,792.75
ANTI-INFECTIVE AGENTS	00006022761	ISENTRESS 400 MG TAB	B	F	1.8%	81,923.86	6	1,861.91	14	1,897.49
ANTI-INFECTIVE AGENTS	15584010101	ATRIPLA 600-200-300 MG TAB	B	F	1.7%	79,639.15	7	3,792.34	1	3,546.61
ANALGESIC, ANTI-INFLAMMATORY OR ANTIPYRETIC	00074379902	HUMIRA 40 MG/0.8 ML KIT	B	F	1.5%	67,901.45	8	1,741.06	5	2,100.25
ANTINEOPLASTICS	00004110150	XELODA 500 MG TAB	B	F	1.4%	66,134.10	9	1,889.55	33	2,370.50
RESPIRATORY THERAPY AGENTS	00597001314	COMBIVENT 18-103 MCG/ACTUATION AERO	B	F	1.1%	51,030.30	10	408.24	32	480.88
ANTI-INFECTIVE AGENTS	00003362212	REYATAZ 300 MG CAP	B	F	1.0%	46,667.00	11	3,111.13	20	1,877.14
ENDOCRINE	00088222033	LANTUS 100 UNIT/ML SOLN	B	F	0.9%	43,800.58	12	438.01	12	423.27
ANTI-INFECTIVE AGENTS	00074333330	NORVIR 100 MG TAB	B	F	0.9%	41,367.05	13	678.15	46	601.72
ANTI-INFECTIVE AGENTS	61958040101	VIREAD 300 MG TAB	B	F	0.9%	39,449.55	14	1,195.44	23	1,753.37
ANTI-INFECTIVE AGENTS	00004003822	VALCYTE 450 MG TAB	B	F	0.8%	37,805.85	15	4,200.65	60	2,907.11
ANTI-INFECTIVE AGENTS	51167010001	INCIVEK 375 MG TAB	B	F	0.8%	36,617.00	16	18,308.50	8	16,265.56

4395

Non – Medicare

Top 25 Drugs by Net Claims

Group Name: HEALTH SERVICE SYSTEM (CITY AND COUNTY OF SF)

Group Number: 888

Subgroups: 0001,7001

Region: Northern California

Contract Period: 01/01/2014 – 12/31/2014

	Jan12 – Dec12
Average Members *:	4,605

Therapeutic Class	NDC	Drug Name	Brand/ Generic	Formulary /Non- For mulary	% of Total Net Claims	Group			Health Plan	
						Net Claims	Rank	Net Claims Per Script	Rank	Net Claims Per Script
ANTI-INFECTIVE AGENTS	59676056101	PREZISTA 400 MG TAB	B	F	0.8%	36,602.10	17	1,143.82	64	1,753.63
HEMATOLOGICAL AGENTS	55513092410	NEUPOGEN 300 MCG/0.5 ML SYRG	B	F	0.8%	34,679.05	18	2,039.94	22	2,044.85
GASTROINTESTINAL THERAPY AGENTS	58468013001	RENVELA 800 MG TAB	B	F	0.7%	33,614.05	19	1,400.59	54	1,332.04
ENDOCRINE	00169183411	NOVOLIN N 100 UNIT/ML SUSP	B	F	0.7%	33,443.62	20	118.18	18	117.61
RESPIRATORY THERAPY AGENTS	00085461001	DULERA 200-5 MCG/ACTUATION HFAA	B	F	0.7%	30,591.85	21	270.72	37	229.97
DRUGS TO TREAT ERECTILE DYFUNCTION	00173083113	LEVITRA 20 MG TAB	B	F	0.7%	30,576.28	22	59.26	21	73.47
GASTROINTESTINAL THERAPY AGENTS	00430075227	ASACOL 400 MG TBEC	B	F	0.7%	30,376.80	23	675.04	17	1,138.62
RESPIRATORY THERAPY AGENTS	00006011754	SINGULAIR 10 MG TAB	B	N	0.7%	30,103.65	24	424.00	15	407.73
ANALGESIC, ANTI-INFLAMMATORY OR ANTIPYRETIC	59011048010	OXYCONTIN 80 MG TB12	B	N	0.7%	30,071.45	25	2,313.19	40	2,535.37
		ALL OTHER			66.3%	$3,062,445.05		$63.64		$60.23
	TOTAL:				100.0 %	$4,617,650.99		$92.54		$75.14

* Includes actives and /or pre 65 Retirees Only.

4396

Created On: 4/9/2013
NPS RQR Number: 6427167

SPAS RQR Number/Set ID: 393288-10400-278-1
NPS RQR Name: HSS Early Retirees

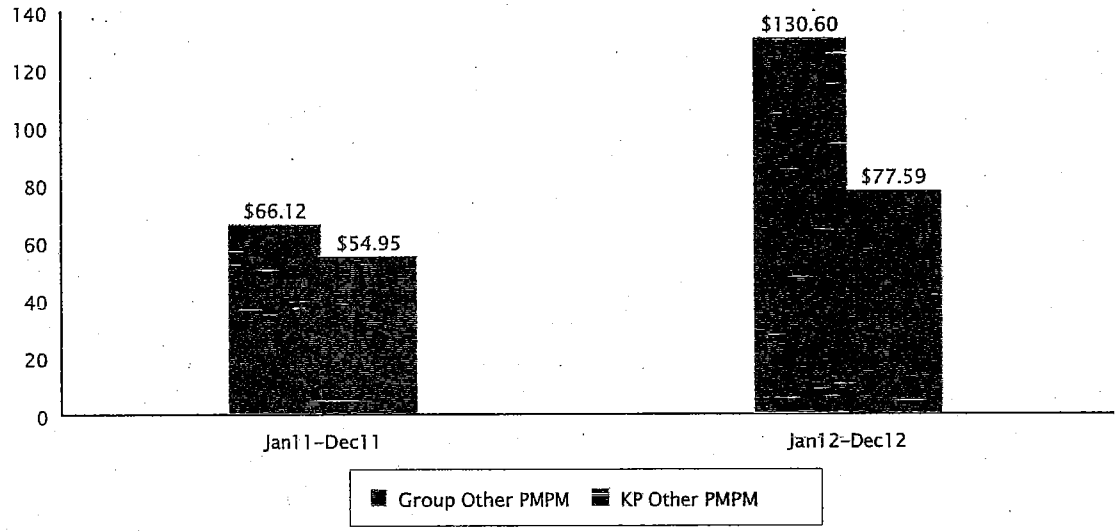
Other – $ PMPM

Group Name: HEALTH SERVICE SYSTEM (CITY AND COUNTY OF SF)
Group Number(s): 888
Subgroup(s): 0001,7001

Region: Northern California
Contract Period: 01/01/2014-12/31/2014

	Jan11 – Dec11	Jan12 – Dec12
Average Members*:	4,670	4,605

Other $ PMPM



Other $ PMPM *

Service Category	Jan11 – Dec11	Change	Jan12 – Dec12
Ambulance	$8.58	19.6%	$10.26
DME	5.91	31.3%	7.76
Home Health	2.64	158.0%	6.81
Integrated Care Management – Variable – Rx	0.00	N/A	18.80
Integrated Care Management – Variable – Medical	0.00	N/A	51.62
Integrated Care Management – Fixed	27.50	(34.4)%	18.05
Other Medical Services	21.50	(19.6)%	17.29
Total Other $ PMPM	**$66.12**	**97.5%**	**$130.60**
Group to Health Plan Ratio	120.3%	39.9%	168.3%

* Includes Actives and/or pre 65 Retirees only.

High Cost Claimants

Region: Northern California

Contract Period: 01/01/2014-12/31/2014

Group Name: HEALTH SERVICE SYSTEM (CITY AND COUNTY OF SF)

Group Number(s): 888

Subgroup(s): 0001,7001

Jan12 - Dec12

Average Members*: 4,605

Product Type: HMO

Claims In Excess Of: $550,000

Pooling Point: $550,000

Person	Member Status	Primary Diagnosis	Claims Per Member	% of Total Claims	Claims Over Pooling Point
Person 1	Terminated	9961-MECH COMP OTH VASCULAR DEVICE IMPLANT&GRAFT	$994,604.12	2.5%	$444,604.12
Total for High Cost Members:			$994,604.12	2.5 %	
All Other Claimants Total:			$39,228,489.00	97.5 %	
Total for All Claimants:			$40,223,093.12	100.0 %	$444,604.12

* Includes Actives and /or pre 65 Retirees Only.

Monthly Paid Claims

Non-Medicare

Region: Northern California

Contract Period: 01/01/2014 - 12/31/2014

Group Name: HEALTH SERVICE SYSTEM (CITY AND COUNTY OF SF)

Group Numbers: 888

Subgroups: 0001,7001

	Jan11 - Dec11	Jan12 - Dec12
Average Members *:	4,670	4,605

	Medical Claims			Total Medical Claims	Rx Claims	Total Claims	PMPM Claims	Members
	Inpatient	Outpatient	Other					
Jan 12	$1,408,175	$858,391	$631,876	$2,898,442	$385,619	$3,284,061	$711.14	4,618
Feb 12	1,127,340	876,533	562,462	2,566,334	390,793	2,957,127	642.57	4,602
Mar 12	1,437,792	947,194	825,796	3,210,782	405,925	3,616,706	789.67	4,580
Apr 12	781,490	1,211,070	455,900	2,448,459	354,323	2,802,782	613.17	4,571
May 12	2,115,844	1,168,275	684,621	3,968,739	407,493	4,376,232	959.49	4,561
Jun 12	1,427,033	991,097	515,728	2,933,858	366,415	3,300,273	725.97	4,546
Jul 12	1,376,735	1,109,267	596,056	3,082,058	403,297	3,485,355	739.68	4,712
Aug 12	1,117,259	1,067,047	681,389	2,865,695	438,643	3,304,338	708.48	4,664
Sep 12	1,420,523	964,758	566,730	2,952,011	338,632	3,290,643	703.28	4,679
Oct 12	1,338,606	1,064,268	612,795	3,015,670	420,241	3,435,911	740.02	4,643
Nov 12	1,557,144	827,126	553,963	2,938,233	353,144	3,291,378	720.84	4,566
Dec 12	1,358,103	837,514	529,544	2,725,161	353,126	3,078,287	681.34	4,518
Total	**$16,466,042**	**$11,922,541**	**$7,216,859**	**$35,605,442**	**$4,617,651**	**$40,223,093**	**$727.89**	**55,260**
Jan 11	$1,463,136	$947,459	$306,521	$2,717,116	$365,368	$3,082,484	$655.01	4,706
Feb 11	1,287,724	994,033	290,889	2,572,645	353,660	2,926,305	620.51	4,716
Mar 11	2,456,893	1,140,207	369,685	3,966,785	369,108	4,335,892	919.21	4,717
Apr 11	1,670,259	865,083	308,305	2,843,647	332,261	3,175,909	689.67	4,605
May 11	989,419	874,042	306,158	2,169,619	361,047	2,530,666	551.94	4,585
Jun 11	1,390,406	1,165,849	292,336	2,848,591	357,996	3,206,587	698.30	4,592
Jul 11	1,787,052	1,065,105	333,020	3,185,177	325,379	3,510,556	742.03	4,731
Aug 11	1,199,000	1,111,233	337,409	2,647,641	368,986	3,016,628	638.98	4,721
Sep 11	997,255	997,318	285,651	2,280,224	340,137	2,620,362	558.24	4,694
Oct 11	1,825,437	935,024	284,537	3,044,998	399,348	3,444,346	734.72	4,688
Nov 11	1,222,585	973,724	298,317	2,494,626	409,724	2,904,350	623.92	4,655
Dec 11	1,368,535	737,490	292,398	2,398,423	373,724	2,772,147	598.61	4,631
Total	**$17,657,701**	**$11,806,568**	**$3,705,223**	**$33,169,493**	**$4,356,739**	**$37,526,232**	**$669.62**	**56,041**

* Includes actives and /or pre 65 Retirees Only.

Rate and Benefit Summary – Commercial

Region: Northern California

Group Name: HEALTH SERVICE SYSTEM (CITY AND COUNTY OF SF)

Contract Period: 01/01/2014 – 12/31/2014

Group Numbers: 888

Subgroups: 0001,0028,7001,8500

	Jan11 – Dec11	Jan12 – Dec12
Average Members*:	4,670	4,605

Product Type: HMO

Quote Name: TRADITIONAL HMO

Current Rates

Rate Tiers	Medical	Chiro	Dental	Total	Ratio
Subscriber only	$1,070.95	$1.32	$0.00	$1,072.27	1.00
Subscriber and 1 dependent	1,600.82	2.64	0.00	1,603.46	1.50
Subscriber and 2 or more dependents	2,040.62	3.73	0.00	2,044.35	1.91

Proposed Rates

Rate Tiers	Subscribers	Medical	%Change	Chiro	%Change	Dental	%Change	Total	%Change	Ratio
Subscriber only	1,177	$1,127.31	5.26%	$1.32	0.00%	$0.00	0.00%	$1,128.63	5.26%	1.00
Subscriber and 1 dependent	1,153	1,685.06	5.26%	2.64	0.00%	0.00	0.00%	1,687.70	5.25%	1.50
Subscriber and 2 or more dependents	274	2,147.99	5.26%	3.74	0.27%	0.00	0.00%	2,151.73	5.25%	1.91

Estimated Monthly Cost: $3,863,890

Billing Frequency: Monthly

Unassigned 65 + Retiree Rates – Single

	Rate	Members
Neither A nor B	$1,128.63	62
A and B	1,128.63	37
A Only	1,128.63	19
B Only	1,128.63	0
Under 65 NKR	1,128.63	0
65 Plus NKR	1,128.63	0

Proposed HMO Benefits

Annual Deductible: Individual / Family per calendar year(s) : None

Out-of-Pocket Maximum: Individual / Family : $1500 per member / $3000 per family

Lifetime Maximum: Individual / Family : None

Prescription Drugs : R:HC2:2T:$15/$5/30 DAY;$30/$10 100 DAY MOI;50% MR INF,IMPOT,RXGZIVF

Outpatient

Provider Visits : HC2 $20/VISIT; $0 PREVENTIVE

Other Professional

Surgery – Outpatient Services : R: HC2 $35/PROCEDURE; $20/ABORTION; $0 COLONOSCOPY; TG, STER

Special Procedures : HCR $0 OUTPT/ENCOUNTER

Chiropractic : $15/VISIT TO 30 VISITS; $50 ALLOW/CALNDR YR

Infertility : $20/VISIT; $100/ADMIT; $0 LAB, IMAG & SPEC/ENCOUNTER

Multidisciplinary Rehab – Inpatient & Outpatient : $20/DAY OUTP; $100/ADMIT INPT

Therapy Services : $20/VISIT

Home Health Services : $0/VISIT PART TIME INTERMITTENT CARE; 3 VISITS/DAY; 100 VISITS/YR

Hospice : $0/SERVICE

Ambulance and Emergency Services

Medical Transportation Services : $0/TRIP

Emergency Care : $100/VISIT

* Includes Actives and/or pre 65 Retirees only.

Rate and Benefit Summary – Commercial

Region: Northern California

Group Name: HEALTH SERVICE SYSTEM (CITY AND COUNTY OF SF)

Contract Period: 01/01/2014 – 12/31/2014

Group Numbers: 888

Subgroups: 0001,0028,7001,8500

	Jan11 – Dec11	Jan12 – Dec12
Average Members*:	4,670	4,605

Product Type: HMO

Quote Name: TRADITIONAL HMO

Laboratory and Imaging

Laboratory Services : HCR $0 OUTPT/ENCOUNTER; $0 PREVENTIVE

Diagnostic and Therapeutic Imaging : HCR $0/ENCOUNTER; $0 CT/MRI/PET/PROCEDURE; $0 PREVENTIVE

Hospital Inpatient

Hospital Services : R: $100/ADMIT; $100 TRANSGENDER

Extended Care : $0/ADMIT TO 100 DAYS/BNFT PRD

Mental Health and Chemical Dependency

Mental Health Outpatient : $20/UNLIMITED VISITS; AB88

Mental Health Inpatient : $100/ADMIT; $0 PART; $0 INTN; UNLIMITED

Chemical Dependency Outpatient Program : $20/VISIT INDV; $5/VISIT GRP, DAY, IOP

Chemical Dependency Inpatient Program : $100/ADMIT; $100 TRRS/ADMIT; $100 RTP/ADMIT

Other

Durable Medical Equipment : HC2 $0 BASE, FORMULARY LIST, AND DMSXDEV

Prosthetics & Orthotics : $0 BASE; FORMULARY LIST & SPECIAL FOOTWEAR

Optical Dispensing : R: 25% EYEWR DISCOUNT

Hearing Aids : $2500 ALLOW/DEVICE; 1 DEVICE/EAR; 2 DEVICE(S)/36 MONTHS

Allergy : $5 INJECTIONS

Dermatology : $0/TREATMENT

Health Education : HCR $0 IND/VISIT; $0 GRP/CLASS; $0 PREVENTIVE

LGYS/CDIP171/CDOP7/CHIR18/DERM5/DME5/DRUG1098/EMRG15/EXTC21/GIFT20/HEAR21/HLTH18/HOME21/HOSP107/HSPC1/IMAG12/INF32/LAB12/MDTR1/MHI
P197/MHOP184/OPT251/P&O3/PROV692/RHAB91/SPEC12/SURG435/THER9

* Includes Actives and/or pre 65 Retirees only.

Rate Assumptions and Requirements

Region: Northern California

Group Name: HEALTH SERVICE SYSTEM (CITY AND COUNTY OF SF)

Contract Period: 01/01/2014 - 12/31/2014

Group Numbers: 888

Subgroups: 0001,0028,7001,8500

	Jan11 - Dec11	Jan12 - Dec12
Average Members:	4,670	4,605

KP Offered: Alongside other carrier(s)

Quotes Included

TRADITIONAL HMO - 10410181
HMO CHIRO NCR - 10410182

Proposal Assumptions

The proposed rates and benefits included on the Rate and Benefit Summary page are based on the **participation and contribution requirements** described below. If any of the following are not met, Kaiser Permanente (KP) reserves the right to withdraw our rate proposal, decline coverage, re-rate this proposal or terminate your Group Agreement.

1. **Group-specific requirements:**
None

2. **Rating Assumptions:**
Rates assume a 12-month policy period of 1/1/2014 through 12/31/2014 unless otherwise specified above.
The rates and benefits in this proposal include the Federal Health Care Reform requirements for dependent coverage to age 26 and the elimination of lifetime maximums, including durable medical equipment (DME as defined by Federal Health Care Reform) annual maximums for contracts with renewal dates of October 1, 2010 or later. KP reserves the right to modify the rates and benefits if we receive further clarification of Federal Health Care Reform requirements, or to incorporate other applicable Federal Health Care Reform requirements. In addition, Kaiser Permanente reserves the right to make any change in these rates and benefits due to changes in State or Federal legislation or regulatory action.
KP reserves the right to rerate if actual enrollment results in a +/-10% change in the rates from what was assumed at the time of this quote. Examples of changes that may impact rates include, but are not limited to, the following:
a. A change in the demographic factor.
b. A change in the average family size or subscriber distribution.
c. A change in the number of subscribers enrolled in KP.
d. A change in the number of plans offered alongside KP.
e. A change in the benefit design of a plan offered alongside KP.
f. A change in the employer contribution formula.
KP reserves the right to change the rates in the event the employer funds, or offers to fund, all or part of an individual or family deductible, copayment or coinsurance which is applicable under the KP plan unless specifically noted in the Group-Specific Requirements above.

3. **Participation and contribution requirements:**
a. Proposed rates and benefits assume 75% of overall eligible group employees enroll in a company-sponsored plan excluding those waiving for alternative group coverage.
b. Proposal assumes employer pays at least 50% of the employee only cost and is non-discriminatory.

4. **Quote assumes KP is offered alongside another health care plan**
KP must be offered on conditions that are no less favorable than those for other health care plans. Examples include, but are not limited to, the following:
a. KP is offered to all eligible employees.
b. KP has access to the employer and to the employees on the same basis as all other health care plans offered.
c. The employer's contribution formula does not put KP in a disadvantaged position. Acceptable formulas include, but are not limited to, fixed employer dollar or percentage contribution.
d. Basic and optional benefits such as DME, prescription drugs, and infertility are comparable among all health care plans offered, however, KP will allow preventive services as defined by Health and Human Services (HHS) to vary if specifically approved by underwriting.
e. KP is not offered alongside plans with pre-existing condition provisions, health condition exceptions or lifetime coverage limits.
f. If early retirees are covered, the employer offers all health care plans to early retirees on the same basis.
g. Eligibility rules such as dependent age limits and waiting periods for new hires are the same for all health care plans.

h. No other plan is allowed preferential treatment that adversely affects KP.
i. The number of employee subscribers enrolled in KP must be the greater of 5 or 5% of the total number of employees enrolled in all health plans in regions where KP is offered.
j. Kaiser Permanente must NOT be offered along side an age-rated health care plan.
k. Rate tier ratios and their definitions should be the same among all health plans offered by the group (employer).

5. **Product-specific participation requirements:**

Additional Kaiser Permanente Medicare Senior Advantage (KPSA), Medicare Plus or Medicare Cost Requirements:

a. Members must have Medicare Parts A and B to enroll in Medicare Senior Advantage (KPSA), Medicare Plus or Medicare Cost and be eligible for Medicare rates. Members with only Part B may also enroll but their rates will be subject to a surcharge.
b. Medicare eligible members must reside in the approved Medicare Senior Advantage (KPSA), Medicare Plus or Medicare Cost service areas to receive benefits for the group Medicare Senior Advantage (KPSA), Medicare Plus or Medicare Cost offering.
c. Preliminary Medicare Senior Advantage (KPSA), Medicare Plus or Medicare Cost rates and benefits are subject to change.
d. Medicare Senior Advantage (KPSA), Medicare Plus or Medicare Cost products may not be available for sale in all KP regions.

Additional Out-of-Area Product Requirements:

a. All employees offered KP Out-of-Area products must reside and work outside the KP service area.

6. **Proposal requires eligibility for KP plan based on the following:**

a. Employer - the employer cannot be considered a small group according to state law.
b. Actives:
   - The group (employer) must be related to those offered a KP plan by virtue of employment. This includes when the group contract is with a Taft-Hartley Trust, Professional Employer Organization (PEO), association or Joint Power of Authority (JPA).
   - An eligible employee is defined as an active, permanent employee who is on the employer's payroll, and working a minimum of 20 hours per week. Temporary and independent contractors (i.e., 1099 employees) are not eligible unless noted otherwise in this Rate Assumptions and Requirements document.
   - The employee must live or work in the service area specific to the product they enroll in.
   - 100% of eligible employees must be covered by Worker's Compensation, where mandated by law.
c. New enrollees:
   The probationary period for new employees is non-discriminatory and reflects no more than a 90-day waiting period unless noted otherwise in this Rate Assumptions and Requirements document.
d. COBRA
   - It is the responsibility of the employer group to enroll eligible members into the KP COBRA plan in compliance with federal law.
   - It is the employer's responsibility to comply with appropriate COBRA statutes.
   - KP will generally include COBRA members as part of the group bill. If individual billing has been arranged, KP will assume responsibility for collecting premiums from COBRA members, only acting as a collection agent on behalf of the group, not as a fiduciary for the group. In addition, KP retains the authority to terminate a direct-billed member for non-payment.
e. Retirees
   - Eligible early retirees must enroll in a health plan at the time of retirement and may later elect to enroll in a KP plan at open enrollment as long as they have maintained continuous enrollment in a health plan since the time of retirement.
   - Early retirees under the age of 65 must be reported to KP and set up as a separate employee class or subgroup.
   - Medicare eligible retirees cannot enroll in the active plan.
   - Applicants for a Medicare Senior Advantage (KPSA), Medicare Plus or Medicare Cost plan must meet all the Medicare eligibility requirements, including those stated in this Rate Assumptions and Requirements document.
f. Dependents
   - If an "in-area" employee has dependents that live outside the service area, the employee and dependents must be enrolled in the same product.

7. **Compliance:**

KP reserves the right to make any change in the employer group's benefits and/or rates due to changes in State or Federal legislation or regulatory action.

Rate Assumptions and Requirements

Group Name: HEALTH SERVICE SYSTEM (CITY AND COUNTY OF SF)

Group Numbers: 888

Subgroups: 0001,0028,7001,8500

Region: Northern California

Contract Period: 01/01/2014 - 12/31/2014

	Jan11 - Dec11	Jan12 - Dec12
Average Members:	4,670	4,605

KP Offered: Alongside other carrier(s)

8. Broker Payment:
Brokers may be paid commissions and other financial incentives by Kaiser Permanente.

The contracting employer must also meet all other group-specific responsibilities and requirements described in your Group Agreement.

Glossary of Terms

Term	Kaiser Foundation Health Plan
Annual Trend	The projected annual percent change in medical and pharmacy expenses applied to a group's claims experience.
Area Factor	A factor that adjusts the manual rate to reflect geographic price differentials.
Average Members	The average monthly membership during the reporting period.
Benefit Adjusted Manual Rate	The average rate for a group's current benefit plan for a particular market segment.
Capping	A method of stabilizing year-to-year rate changes.
COBRA Factor	An adjustment made to the manual rate to reflect the proportion of COBRA enrollees.
Contract Period	The time period during which a rate is valid.
Credibility	The weighting applied to manual, risk or claims-based rates when developing required premium rates.
Demographic Change	An adjustment made in the Projected Claims Calculation to reflect changes in the group demographics that occurred between the experience period and the time of the quote.
Demographic Factor	An adjustment made to the manual rate to reflect a group's current demographics.
Federal Health Insurer Fee	A percent of premium fee paid by insurance carriers for commercial and Medicare business beginning January 1, 2014.
Federal PCORI Fee	A fee per covered life paid by commercial insurers and self-funded plan sponsors to fund the Patient-Centered Outcomes Research Institute (PCORI). PCORI was established by the Affordable Care Act. The PCORI will commission studies that compare drugs, medical devices, tests, surgeries and ways to deliver health care.
Federal Transitional Reinsurance Program Contribution	A fee paid by commercial insurers and third party administrators for self-funded plans from 2014 through 2016 to support reinsurance to individual market insurers covering high risk individuals in Exchanges.
Formulary	A list of preferred drugs based on their effectiveness and value.
Future Benefit Change	An adjustment to the rate to reflect a change in benefits being quoted for the renewal period.
Historical Benefit Change	An adjustment made to historical paid claims to reflect the group's current benefit level.
Incurred Claim Adjustment	An adjustment made to a group's paid claims to convert them to estimated incurred claims.
In-force PMPM Rate	A group's current monthly PMPM (per member per month) rate.
Integrated Care Management (ICM) Fee	This charge, which is currently included in Paid Claims, incorporates services such as chronic conditions management, pharmacy management, clinical access alternatives, telephonic clinical advice, wellness information and coaching, online personal health management, medical and case management, external provider network management, and other care management services that are not billed or can't be done so efficiently. At KP, integrated care management cannot be unbundled, as it is part of the unique care and services the Permanente Medical Groups deliver to get and keep our members healthy.
Kaiser Permanente Senior Advantage (KPSA)	Kaiser Permanente's Medicare Advantage plan, offered in all regions except Ohio and Mid-Atlantic, which offer Medicare Plus (Cost) instead.
Kaiser Permanente Medicare Plus (Cost)	Kaiser Permanente's Medicare Cost plan, offered in Ohio and Mid-Atlantic only. No Medicare Advantage plan is offered in these regions.
Late Payment Charge	A fee added to the rate to compensate KP for a group's late payment history.
Market Segment	Group divisions based on group size and/or line of business such as Labor Trust or National Accounts.
Other Benefits	Benefits that are not included in the manual rate nor in the paid claims.

Glossary of Terms

Term | Kaiser Foundation Health Plan

Other Medical Services (OMS)	Other Medical Services (OMS) is a component of claims that accounts for services that are not easily captured in our claims and encounter systems. OMS includes but is not limited to capitated services, incomplete coding of KP services, COB and third-party liability.
Paid Claims	Paid medical expenses for services provided to a health plan member. These are either the result of an internal service, where prices are based on a fee schedule, or an external claim for services from a non-KP provider. Claims are attributed to the month in which they were paid (external) or reported (internal).
Pooling Charge	The per member per month charge included in the Projected Claims Calculation to compensate for the removal of claims exceeding the pooling point.
Pooling Credit	The total combined medical and prescription drug claims paid above the pooling point. This amount is removed from paid claims in the Projected Claims Calculation.
Pooling Point	The annual threshold above which a member's combined medical and prescription drug claims will be excluded from the group's rate calculation.
Quoted Rate	The renewal rate calculated on a per member per month basis.
Rate Assumptions and Requirements	A component of the customer renewal report package that documents terms and conditions of the rate proposal.
Rating Members	The membership during the rating month used in the renewal.
Rating Month	The month of the membership and benefits used to calculate the renewal.
Report Period	The period of time over which prior claims are aggregated and used to project future claim costs.
Reporting Threshold	Used on the High Cost Claimants report, it is the minimum in total claims in the reporting period required for a member to be displayed. The threshold varies by group size.
Retention	The portion of premium retained by KP to cover Health Plan administration expenses such as billing, member services and marketing.
Risk Factor	A comparison of a group's projected medical expenses to the average based on the group members' demographics and experience period prescription drug use.
Trend Factor	A factor that projects historical claims to a future rating period.
Underwriter Adjustment	An adjustment to the rate made by the underwriter to reflect differences in risk or offering conditions not accounted for elsewhere in the rate development.
Work Status Factor	An adjustment made to the manual rate to reflect the under 65 retiree population's influence on projected medical expenses.

RATE PROPOSAL

HEALTH SERVICE SYSTEM (CITY AND COUNTY OF SF)

Effective from 01/01/2014 through 12/31/2014

Region(s)	Group(s)	Subgroup(s)
Southern California	231003	0001

Table of Contents

Executive Summary

Group Name: HEALTH SERVICE SYSTEM (CITY AND COUNTY OF SF)
Group Number(s): 231003
Subgroup(s): 0001

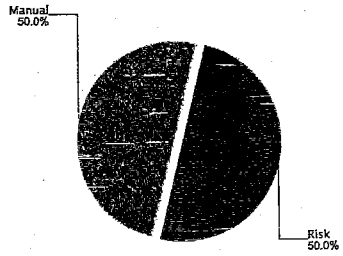
Region: Southern California
Contract Period: 01/01/2014 – 12/31/2014

	Jan11 – Dec11	Jan12 – Dec12
Average Members*:	37	73

Rates**

	Current Rates	Change %	Proposed Rates
TRADITIONAL HMO SCR – EARLY RETIREE: **$20 OV; $100/ADMISSION IP; $100 ER; CHIRO; HEAR;**			
Subscriber only	$1,072.27	5.26%	$1,128.63
Subscriber and 1 dependent	1,603.46	5.25%	1,687.70
Subscriber and 2 or more dependents	2,044.35	5.25%	2,151.73

Credibility



* Includes Actives and /or pre 65 Retirees only.
**Benefit plan descriptions are summarized, please see Rate and Benefit Summary for full descriptions.

Rate Buildup

Group Name: HEALTH SERVICE SYSTEM (CITY AND COUNTY OF SF)
Group Number(s): 231003
Subgroup(s): 0001

Product Type: HMO

Region: Southern California
Contract Period: 01/01/2014 - 12/31/2014
Report Period: Jan 2012 through Dec 2012

	Jan11 - Dec11	Jan12-Dec12
Average Members:	37	73

Rating Month: February 2013
Rating Members: 78

	Medical Calculation	Weight	Factor	Total$	PMPM$
B	**Manual Rate Calculation**				$357.415
B1	Benefit Adjusted Manual Rate		1.00000		
B2	X Area Factor		1.66663		
B3	X Demographic Factor		1.00000		
B4	X Industry Factor		0.99165		
B5	X COBRA Factor		1.21704		
B6	X Work Status Factor				$718.912
B7	Manual PMPM				
B8	Credibility	50%			
C	**Risk Adjusted Calculation**				$357.415
C1	Benefit Adjusted Manual Rate		1.00000		
C2	X Area Factor		2.13050		
C3	X Risk factor				$761.474
C4	Risk Adjusted PMPM				
C5	Credibility	50%			

	Total Rate Calculation	Factor	Mo. Prem.	PMPM$
D	**Total Rate Calculation**		$57,735	$740.192
D1	Blended Rate	1.000000		
D2	X Future Benefit Change		$57,735	$740.192
D3	Adjusted PMPM		2,210	28.330
D4	+ Retention		115	1.470
D5	+ Other Benefits		0	0.000
D6	+ Group Specific Charge		0	0.000
D7	+ Late Payment Charge		396	5.073
D8	+ Federal Health Insurer Fee		423	5.420
D9	+ Federal PCORI Fee/Transitional Reinsurance Program Contribution		0	0.000
D10	+ Premium Tax		0	0.000
D11	+ Commission		$60,878	$780.485
D12	**Uncapped PMPM Premium Requirement**			
E	**Capping**	Increase	$65,329	$837.556
E1	In-Force Rate	(6.81)%	60,878	780.485
E2	Premium Requirement without Benefit Change and Underwriter Adj	0.00%	65,329	837.556
E3	Capping Rate	0.00%	65,329	837.556
E4	**Quoted Rate PMPM before Underwriter Adjustment**	1.01678		
E5	X Underwriter Adjustment	1.68%	66,426	851.610
E6	**Quoted Rate PMPM after Underwriter Adjustment**		4,452	57.071
E7	Capping Adjustment			

Membership – Age and Gender Demographics

Group Name: HEALTH SERVICE SYSTEM (CITY AND COUNTY OF SF)
Group Number(s): 231003
Subgroup(s): 0001

Region: Southern California
Contract Period: 01/01/2014-12/31/2014

4412

Members*

	Average Jan11-Dec11				Average Jan12-Dec12				Current as of Feb13			
Age	Male	Female	Total	Percent	Male	Female	Total	Percent	Male	Female	Total	Percent
0-0	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%
1-4	1	0	1	1.4%	1	0	1	1.4%	0	0	0	0.0%
5-9	1	0	1	3.9%	2	0	2	2.1%	2	0	2	2.6%
10-14	0	0	0	0.0%	1	0	1	0.7%	1	0	1	1.3%
15-19	0	1	1	1.6%	1	1	2	2.2%	0	1	1	1.3%
20-24	1	0	1	1.6%	2	1	3	3.4%	1	3	4	5.1%
25-29	0	1	1	1.4%	0	1	1	1.4%	1	0	1	1.3%
30-34	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%
35-39	0	0	0	0.0%	0	0	0	0.0%	1	0	1	1.3%
40-44	0	2	2	4.1%	0	3	3	4.1%	0	3	3	3.8%
45-49	0	0	0	1.1%	0	0	0	0.0%	0	0	0	0.0%
50-54	5	3	8	22.3%	8	7	15	20.9%	7	7	14	17.9%
55-59	4	3	7	19.4%	6	8	15	20.4%	8	11	19	24.4%
60-64	8	8	16	43.1%	16	15	31	43.1%	15	17	32	41.0%
65-69	0	0	0	0.2%	0	0	0	0.3%	0	0	0	0.0%
70-74	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%
75-79	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%
80-84	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%
85+	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%
Total Members	**19**	**18**	**37**	**100.0%**	**36**	**36**	**73**	**100.0%**	**36**	**42**	**78**	**100.0%**
Percentage	51.7%	48.3%			49.9%	50.1%			46.2%	53.8%		
Health Plan Average Age:	33.4	34.1	33.8		33.4	34.1	33.8		33.4	34.1	33.8	
Group Average Age:	52.9	54.0	53.4		51.6	54.8	53.2		51.3	54.0	52.7	
Average Contract Size:			1.56				1.61				1.70	
Demographic Factor:**							1.68328				1.66663	%Change (1.0)%

* Includes Actives and /or pre 65 Retirees only.
** Each group's Demographic factor is calculated based on its own demographics compared to that of its Market Segment, not based on a comparison with the Health Plan.

Risk Factor Backup

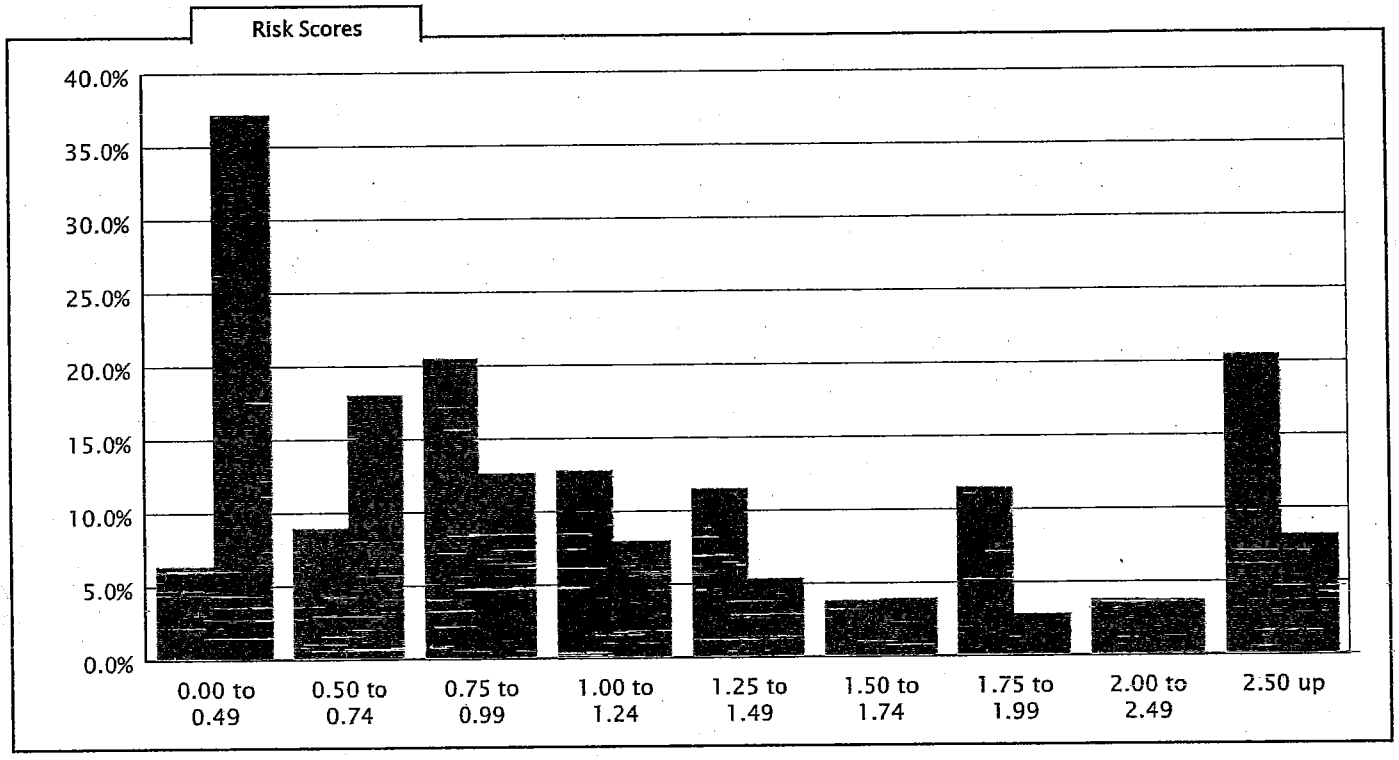
Group Name : HEALTH SERVICE SYSTEM (CITY AND COUNTY OF SF)

Region: Southern California

Group Number(s) : 231003

Contract Period: 01/01/2014 – 12/31/2014

Risk Score Period : February 2013



■ HEALTH SERVICE SYSTEM (CITY AND COUNTY OF SF)

Risk Scores	% of Members	x	Average Score	=	Weighted Average
0.00 to 0.49	6.4 %		0.33214		0.02129
0.50 to 0.74	9.0 %		0.61653		0.05533
0.75 to 0.99	20.5 %		0.87161		0.17879
1.00 to 1.24	12.8 %		1.17110		0.15014
1.25 to 1.49	11.5 %		1.37492		0.15864
1.50 to 1.74	3.8 %		1.63822		0.06301
1.75 to 1.99	11.5 %		1.86364		0.21504
2.00 to 2.49	3.8 %		2.33627		0.08986
> 2.50	20.5 %		5.44391		1.11670
					2.04880

■ Market Segment

% of Members	x	Average Score	=	Weighted Average
37.2 %		0.25945		0.09654
18.0 %		0.53982		0.09738
12.7 %		0.76071		0.09628
8.0 %		0.98143		0.07817
5.4 %		1.20197		0.06453
3.9 %		1.42094		0.05581
2.9 %		1.64262		0.04685
3.8 %		1.95797		0.07393
8.2 %		4.29260		0.35215
				0.96165

Group Risk Factor = $\frac{2.04880}{0.96165}$ = 2.13050 Total Members = 78

KAISER PERMANENTE

KAISER FOUNDATION HEALTH PLAN, INC.

Rate and Benefit Summary – Commercial

Region: Southern California

Group Name: HEALTH SERVICE SYSTEM (CITY AND COUNTY OF SF)

Contract Period: 01/01/2014 – 12/31/2014

Group Numbers: 231003

Subgroups: 0001

	Jan11 – Dec11	Jan12 – Dec12
Average Members*:	37	73

Product Type: HMO

Quote Name: TRADITIONAL HMO SCR – EARLY RETIREE

Current Rates

Rate Tiers	Medical	Chiro	Dental	Total	Ratio
Subscriber only	$1,070.95	$1.32	$0.00	$1,072.27	1.00
Subscriber and 1 dependent	1,600.82	2.64	0.00	1,603.46	1.50
Subscriber and 2 or more dependents	2,040.62	3.73	0.00	2,044.35	1.91

Proposed Rates

Rate Tiers	Subscribers	Medical	%Change	Chiro	%Change	Dental	%Change	Total	%Change	Ratio
Subscriber only	19	$1,127.31	5.26%	$1.32	0.00%	$0.00	0.00%	$1,128.63	5.26%	1.00
Subscriber and 1 dependent	23	1,685.06	5.26%	2.64	0.00%	0.00	0.00%	1,687.70	5.25%	1.50
Subscriber and 2 or more dependents	4	2,147.99	5.26%	3.74	0.27%	0.00	0.00%	2,151.73	5.25%	1.91

Estimated Monthly Cost: $68,868

Billing Frequency: Monthly

Unassigned 65 + Retiree Rates – Single

	Rate	Members
Neither A nor B	$1,128.63	0
A and B	1,128.63	2
A Only	1,128.63	0
B Only	1,128.63	0
Under 65 NKR	1,128.63	0
65 Plus NKR	1,128.63	0

Proposed HMO Benefits

Annual Deductible: Individual / Family per calendar year(s) : None

Out-of-Pocket Maximum: Individual / Family : $1500 per member / $3000 per family

Lifetime Maximum: Individual / Family : None

Prescription Drugs : R:HC2:2T:$15/$5/30 DAY;$30/$10 100 DAY MOI;50% MR INF,IMPOT,RXGZIVF

Outpatient

Provider Visits : HC2 $20/VISIT; $0 PREVENTIVE

Other Professional

Surgery – Outpatient Services : R: HC2 $35/PROCEDURE; $20/ABORTION; $0 COLONOSCOPY; TG, STER

Special Procedures : HCR $0 OUTPT/ENCOUNTER

Chiropractic : $15/VISIT TO 30 VISITS; $50 ALLOW/CALNDR YR

Infertility : $20/VISIT; $100/ADMIT; $0 LAB, IMAG & SPEC/ENCOUNTER

Multidisciplinary Rehab – Inpatient & Outpatient : $20/DAY OUTP; $100/ADMIT INPT

Therapy Services : $20/VISIT

Home Health Services : $0/VISIT PART TIME INTERMITTENT CARE; 3 VISITS/DAY; 100 VISITS/YR

Hospice : $0/SERVICE

Ambulance and Emergency Services

Medical Transportation Services : $0/TRIP

Emergency Care : $100/VISIT

* Includes Actives and/or pre 65 Retirees only.

Rate and Benefit Summary – Commercial

Region: Southern California

Group Name: HEALTH SERVICE SYSTEM (CITY AND COUNTY OF SF)

Contract Period: 01/01/2014 – 12/31/2014

Group Numbers: 231003

Subgroups: 0001

	Jan11 – Dec11	Jan12 – Dec12
Average Members*:	37	73

Product Type: HMO

Quote Name: TRADITIONAL HMO SCR – EARLY RETIREE

Laboratory and Imaging

Laboratory Services : HCR $0 OUTPT/ENCOUNTER; $0 PREVENTIVE

Diagnostic and Therapeutic Imaging : HCR $0/ENCOUNTER; $0 CT/MRI/PET/PROCEDURE; $0 PREVENTIVE

Hospital Inpatient

Hospital Services : R: $100/ADMIT; $100 TRANSGENDER

Extended Care : $0/ADMIT TO 100 DAYS/BNFT PRD

Mental Health and Chemical Dependency

Mental Health Outpatient : $20/UNLIMITED VISITS; AB88

Mental Health Inpatient : $100/ADMIT; $0 PART; $0 INTN; UNLIMITED

Chemical Dependency Outpatient Program : $20/VISIT INDV; $5/VISIT GRP, DAY, IOP

Chemical Dependency Inpatient Program : $100/ADMIT; $100 TRRS/ADMIT; $100 RTP/ADMIT

Other

Durable Medical Equipment : HC2 $0 BASE, FORMULARY LIST, AND DMSXDEV

Prosthetics & Orthotics : $0 BASE; FORMULARY LIST & SPECIAL FOOTWEAR

Hearing Aids : $2500 ALLOW/DEVICE;1 DEVICE/EAR;2 DEVICE/36 MOS

Allergy : $5 INJECTIONS

Dermatology : $0/TREATMENT

Health Education : HCR $0 IND/VISIT; $0 GRP/CLASS; $0 PREVENTIVE

LGY5/CDIP171/CDOP7/CHIR18/DERM5/DME5/DRUG1098/EMRG15/EXTC21/GIFT20/HEAR21/HLTH18/HOME21/HOSP107/HSPC1/IMAG12/INF32/LAB12/MDTR1/MHI 97/MHOP184/P&O3/PROV692/RHAB91/SPEC12/SURG435/THER9

* Includes Actives and/or pre 65 Retirees only.

Rate Assumptions and Requirements

Group Name: HEALTH SERVICE SYSTEM (CITY AND COUNTY OF SF)

Group Numbers: 231003

Subgroups: 0001

Region: Southern California

Contract Period: 01/01/2014 – 12/31/2014

	Jan11 – Dec11	Jan12 – Dec12
Average Members:	37	73

KP Offered: Alongside other carrier(s)

Quotes Included

TRADITIONAL HMO SCR – EARLY RETIREE – 10404889
HMO CHIRO SCR – 10404892

Proposal Assumptions

The proposed rates and benefits included on the Rate and Benefit Summary page are based on the **participation and contribution requirements** described below. If any of the following are not met, Kaiser Permanente (KP) reserves the right to withdraw our rate proposal, decline coverage, re-rate this proposal or terminate your Group Agreement.

1. **Group-specific requirements:**
   None

2. **Rating Assumptions:**
   Rates assume a 12-month policy period of 1/1/2014 through 12/31/2014 unless otherwise specified above.
   The rates and benefits in this proposal include the Federal Health Care Reform requirements for dependent coverage to age 26 and the elimination of lifetime maximums, including durable medical equipment (DME as defined by Federal Health Care Reform) annual maximums for contracts with renewal dates of October 1, 2010 or later. KP reserves the right to modify the rates and benefits if we receive further clarification of Federal Health Care Reform requirements, or to incorporate other applicable Federal Health Care Reform requirements. In addition, Kaiser Permanente reserves the right to make any change in these rates and benefits due to changes in State or Federal legislation or regulatory action.
   KP reserves the right to rerate if actual enrollment results in a +/-10% change in the rates from what was assumed at the time of this quote. Examples of changes that may impact rates include, but are not limited to, the following:
   a. A change in the demographic factor.
   b. A change in the average family size or subscriber distribution.
   c. A change in the number of subscribers enrolled in KP.
   d. A change in the number of plans offered alongside KP.
   e. A change in the benefit design of a plan offered alongside KP.
   f. A change in the employer contribution formula.
   KP reserves the right to change the rates in the event the employer funds, or offers to fund, all or part of an individual or family deductible, copayment or coinsurance which is applicable under the KP plan unless specifically noted in the Group-Specific Requirements above.

3. **Participation and contribution requirements:**
   a. Proposed rates and benefits assume 75% of overall eligible group employees enroll in a company-sponsored plan excluding those waiving for alternative group coverage.
   b. Proposal assumes employer pays at least 50% of the employee only cost and is non-discriminatory.

4. **Quote assumes KP is offered alongside another health care plan**
   KP must be offered on conditions that are no less favorable than those for other health care plans. Examples include, but are not limited to, the following:
   a. KP is offered to all eligible employees.
   b. KP has access to the employer and to the employees on the same basis as all other health care plans offered.
   c. The employer's contribution formula does not put KP in a disadvantaged position. Acceptable formulas include, but are not limited to, fixed employer dollar or percentage contribution.
   d. Basic and optional benefits such as DME, prescription drugs, and infertility are comparable among all health care plans offered, however, KP will allow preventive services as defined by Health and Human Services (HHS) to vary if specifically approved by underwriting.
   e. KP is not offered alongside plans with pre-existing condition provisions, health condition exceptions or lifetime coverage limits.
   f. If early retirees are covered, the employer offers all health care plans to early retirees on the same basis.
   g. Eligibility rules such as dependent age limits and waiting periods for new hires are the same for all health care plans.

h. No other plan is allowed preferential treatment that adversely affects KP.
i. The number of employee subscribers enrolled in KP must be the greater of 5 or 5% of the total number of employees enrolled in all health plans in regions where KP is offered.
j. Kaiser Permanente must NOT be offered along side an age-rated health care plan.
k. Rate tier ratios and their definitions should be the same among all health plans offered by the group (employer).

5. **Product-specific participation requirements:**

Additional Kaiser Permanente Medicare Senior Advantage (KPSA), Medicare Plus or Medicare Cost Requirements:

a. Members must have Medicare Parts A and B to enroll in Medicare Senior Advantage (KPSA), Medicare Plus or Medicare Cost and be eligible for Medicare rates. Members with only Part B may also enroll but their rates will be subject to a surcharge.
b. Medicare eligible members must reside in the approved Medicare Senior Advantage (KPSA), Medicare Plus or Medicare Cost service areas to receive benefits for the group Medicare Senior Advantage (KPSA), Medicare Plus or Medicare Cost offering.
c. Preliminary Medicare Senior Advantage (KPSA), Medicare Plus or Medicare Cost rates and benefits are subject to change.
d. Medicare Senior Advantage (KPSA), Medicare Plus or Medicare Cost products may not be available for sale in all KP regions.

Additional Out-of-Area Product Requirements:

a. All employees offered KP Out-of-Area products must reside and work outside the KP service area.

6. **Proposal requires eligibility for KP plan based on the following:**

a. Employer - the employer cannot be considered a small group according to state law.
b. Actives:
   - The group (employer) must be related to those offered a KP plan by virtue of employment. This includes when the group contract is with a Taft-Hartley Trust, Professional Employer Organization (PEO), association or Joint Power of Authority (JPA).
   - An eligible employee is defined as an active, permanent employee who is on the employer's payroll, and working a minimum of 20 hours per week. Temporary and independent contractors (i.e., 1099 employees) are not eligible unless noted otherwise in this Rate Assumptions and Requirements document.
   - The employee must live or work in the service area specific to the product they enroll in.
   - 100% of eligible employees must be covered by Worker's Compensation, where mandated by law.
c. New enrollees:
   The probationary period for new employees is non-discriminatory and reflects no more than a 90-day waiting period unless noted otherwise in this Rate Assumptions and Requirements document.
d. COBRA
   - It is the responsibility of the employer group to enroll eligible members into the KP COBRA plan in compliance with federal law.
   - It is the employer's responsibility to comply with appropriate COBRA statutes.
   - KP will generally include COBRA members as part of the group bill. If individual billing has been arranged, KP will assume responsibility for collecting premiums from COBRA members, only acting as a collection agent on behalf of the group, not as a fiduciary for the group. In addition, KP retains the authority to terminate a direct-billed member for non-payment.
e. Retirees
   - Eligible early retirees must enroll in a health plan at the time of retirement and may later elect to enroll in a KP plan at open enrollment as long as they have maintained continuous enrollment in a health plan since the time of retirement.
   - Early retirees under the age of 65 must be reported to KP and set up as a separate employee class or subgroup.
   - Medicare eligible retirees cannot enroll in the active plan.
   - Applicants for a Medicare Senior Advantage (KPSA), Medicare Plus or Medicare Cost plan must meet all the Medicare eligibility requirements, including those stated in this Rate Assumptions and Requirements document.
f. Dependents
   - If an "in-area" employee has dependents that live outside the service area, the employee and dependents must be enrolled in the same product.

7. **Compliance:**

KP reserves the right to make any change in the employer group's benefits and/or rates due to changes in State or Federal legislation or regulatory action.

Rate Assumptions and Requirements

Group Name: HEALTH SERVICE SYSTEM (CITY AND COUNTY OF SF)

Group Numbers: 231003

Subgroups: 0001

Region: Southern California

Contract Period: 01/01/2014 – 12/31/2014

	Jan11 – Dec11	Jan12 – Dec12
Average Members:	37	73

KP Offered: Alongside other carrier(s)

8. **Broker Payment:**
Brokers may be paid commissions and other financial incentives by Kaiser Permanente.

The contracting employer must also meet all other group-specific responsibilities and requirements described in your Group Agreement.

Glossary of Terms

Term | Kaiser Foundation Health Plan

Annual Trend	The projected annual percent change in medical and pharmacy expenses applied to a group's claims experience.
Area Factor	A factor that adjusts the manual rate to reflect geographic price differentials.
Average Members	The average monthly membership during the reporting period.
Benefit Adjusted Manual Rate	The average rate for a group's current benefit plan for a particular market segment.
Capping	A method of stabilizing year-to-year rate changes.
COBRA Factor	An adjustment made to the manual rate to reflect the proportion of COBRA enrollees.
Contract Period	The time period during which a rate is valid.
Credibility	The weighting applied to manual, risk or claims-based rates when developing required premium rates.
Demographic Change	An adjustment made in the Projected Claims Calculation to reflect changes in the group demographics that occurred between the experience period and the time of the quote.
Demographic Factor	An adjustment made to the manual rate to reflect a group's current demographics.
Federal Health Insurer Fee	A percent of premium fee paid by insurance carriers for commercial and Medicare business beginning January 1, 2014.
Federal PCORI Fee	A fee per covered life paid by commercial insurers and self-funded plan sponsors to fund the Patient-Centered Outcomes Research Institute (PCORI). PCORI was established by the Affordable Care Act. The PCORI will commission studies that compare drugs, medical devices, tests, surgeries and ways to deliver health care.
Federal Transitional Reinsurance Program Contribution	A fee paid by commercial insurers and third party administrators for self-funded plans from 2014 through 2016 to support reinsurance to individual market insurers covering high risk individuals in Exchanges.
Formulary	A list of preferred drugs based on their effectiveness and value.
Future Benefit Change	An adjustment to the rate to reflect a change in benefits being quoted for the renewal period.
Historical Benefit Change	An adjustment made to historical paid claims to reflect the group's current benefit level.
Incurred Claim Adjustment	An adjustment made to a group's paid claims to convert them to estimated incurred claims.
In-force PMPM Rate	A group's current monthly PMPM (per member per month) rate.
Integrated Care Management (ICM) Fee	This charge, which is currently included in Paid Claims, incorporates services such as chronic conditions management, pharmacy management, clinical access alternatives, telephonic clinical advice, wellness information and coaching, online personal health management, medical and case management, external provider network management, and other care management services that are not billed or can't be done so efficiently. At KP, integrated care management cannot be unbundled, as it is part of the unique care and services the Permanente Medical Groups deliver to get and keep our members healthy.
Kaiser Permanente Senior Advantage (KPSA)	Kaiser Permanente's Medicare Advantage plan, offered in all regions except Ohio and Mid-Atlantic, which offer Medicare Plus (Cost) instead.
Kaiser Permanente Medicare Plus (Cost)	Kaiser Permanente's Medicare Cost plan, offered in Ohio and Mid-Atlantic only. No Medicare Advantage plan is offered in these regions.
Late Payment Charge	A fee added to the rate to compensate KP for a group's late payment history.
Market Segment	Group divisions based on group size and/or line of business such as Labor Trust or National Accounts.
Other Benefits	Benefits that are not included in the manual rate nor in the paid claims.

Glossary of Terms

Term	Kaiser Foundation Health Plan
Other Medical Services (OMS)	Other Medical Services (OMS) is a component of claims that accounts for services that are not easily captured in our claims and encounter systems. OMS includes but is not limited to capitated services, incomplete coding of KP services, COB and third-party liability.
Paid Claims	Paid medical expenses for services provided to a health plan member. These are either the result of an internal service, where prices are based on a fee schedule, or an external claim for services from a non-KP provider. Claims are attributed to the month in which they were paid (external) or reported (internal).
Pooling Charge	The per member per month charge included in the Projected Claims Calculation to compensate for the removal of claims exceeding the pooling point.
Pooling Credit	The total combined medical and prescription drug claims paid above the pooling point. This amount is removed from paid claims in the Projected Claims Calculation.
Pooling Point	The annual threshold above which a member's combined medical and prescription drug claims will be excluded from the group's rate calculation.
Quoted Rate	The renewal rate calculated on a per member per month basis.
Rate Assumptions and Requirements	A component of the customer renewal report package that documents terms and conditions of the rate proposal.
Rating Members	The membership during the rating month used in the renewal.
Rating Month	The month of the membership and benefits used to calculate the renewal.
Report Period	The period of time over which prior claims are aggregated and used to project future claim costs.
Reporting Threshold	Used on the High Cost Claimants report, it is the minimum in total claims in the reporting period required for a member to be displayed. The threshold varies by group size.
Retention	The portion of premium retained by KP to cover Health Plan administration expenses such as billing, member services and marketing.
Risk Factor	A comparison of a group's projected medical expenses to the average based on the group members' demographics and experience period prescription drug use.
Trend Factor	A factor that projects historical claims to a future rating period.
Underwriter Adjustment	An adjustment to the rate made by the underwriter to reflect differences in risk or offering conditions not accounted for elsewhere in the rate development.
Work Status Factor	An adjustment made to the manual rate to reflect the under 65 retiree population's influence on projected medical expenses.

888 Health Service System (City and County of San Francisco)

Principal Benefits for Kaiser Permanente Traditional Plan (1/1/14—12/31/14)

The Services described below are covered only if all of the following conditions are satisfied:

- The Services are Medically Necessary
- The Services are provided, prescribed, authorized, or directed by a Plan Physician and you receive the Services from Plan Providers inside our Northern California Region Service Area (your Home Region), except where specifically noted to the contrary in the *Evidence of Coverage* (*EOC*) for authorized referrals, hospice care, Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, and emergency ambulance Services

Annual Out-of-Pocket Maximum for Certain Services	
For Services subject to the maximum, you will not pay any more Cost Sharing during a calendar year if the Copayments and Coinsurance you pay for those Services add up to one of the following amounts:	
For self-only enrollment (a Family of one Member)	$1,500 per calendar year
For any one Member in a Family of two or more Members	$1,500 per calendar year
For an entire Family of two or more Members	$3,000 per calendar year
Deductible	None

Lifetime Maximum	
Services covered under "Transgender Surgery" in the *EOC*	$75,000
All other Services	None
Professional Services (Plan Provider office visits)	**You Pay**
Most primary and specialty care consultations, exams, and treatment	$20 per visit
Routine physical maintenance exams, including well-woman exams	No charge
Well-child preventive exams (through age 23 months)	No charge
Family planning counseling and consultations	No charge
Scheduled prenatal care exams and first postpartum follow-up consultation and exam	No charge
Eye exams for refraction	No charge
Hearing exams	No charge
Urgent care consultations, exams, and treatment	$20 per visit
Physical, occupational, and speech therapy	$20 per visit
Outpatient Services	**You Pay**
Outpatient surgery and certain other outpatient procedures	$35 per procedure
Allergy injections (including allergy serum)	$5 per visit
Most immunizations (including the vaccine)	No charge
Most X-rays and laboratory tests	No charge
Health education:	
Covered individual health education counseling	No charge
Covered health education programs	No charge
Hospitalization Services	**You Pay**
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	$100 per admission
Emergency Health Coverage	**You Pay**
Emergency Department visits	$100 per visit

Note: This Cost Sharing does not apply if admitted directly to the hospital as an inpatient for covered Services (see "Hospitalization Services" for inpatient Cost Sharing).

Ambulance Services	**You Pay**
Ambulance Services	No charge
Prescription Drug Coverage	**You Pay**
Covered outpatient items in accord with our drug formulary guidelines:	
Most generic items at a Plan Pharmacy	$5 for up to a 30-day supply, $10 for a 31- to 60-day supply, or $15 for a 61- to 100-day supply
Most generic refills through our mail-order service	$5 for up to a 30-day supply or $10 for a 31- to 100-day supply

Benefit Summary

(continued)

Most brand-name items at a Plan Pharmacy	$15 for up to a 30-day supply, $30 for a 31- to 60-day supply, or $45 for a 61- to 100-day supply
Most brand-name refills through our mail-order service	$15 for up to a 30-day supply or $30 for a 31- to 100-day supply

Durable Medical Equipment	You Pay
Covered durable medical equipment for home use in accord with our durable medical equipment formulary guidelines	No charge

Mental Health Services	You Pay
Inpatient psychiatric hospitalization	$100 per admission
Individual outpatient mental health evaluation and treatment	$20 per visit
Group outpatient mental health treatment	$10 per visit

Chemical Dependency Services	You Pay
Inpatient detoxification	$100 per admission
Individual outpatient chemical dependency evaluation and treatment	$20 per visit
Group outpatient chemical dependency treatment	$5 per visit

Home Health Services	You Pay
Home health care (up to 100 visits per calendar year)	No charge

Other	You Pay
Hearing aid(s) every 36 months	Amount in excess of $2,500 Allowance per aid
Skilled nursing facility care (up to 100 days per benefit period)	No charge
Covered external prosthetic devices, orthotic devices, and ostomy and urological supplies	No charge
All Services related to covered conception by artificial means (one treatment cycle per lifetime)	50% Coinsurance
Hospice care	No charge

This is a summary of the most frequently asked-about benefits. This chart does not explain benefits, Cost Sharing, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and Cost Sharing. For a complete explanation, please refer to the *EOC*. Please note that we provide all benefits required by law (for example, diabetes testing supplies).

231003 Health Service System (City and County

Principal Benefits for Kaiser Permanente Traditional Plan (1/1/14—12/31/14)

The Services described below are covered only if all of the following conditions are satisfied:

- The Services are Medically Necessary
- The Services are provided, prescribed, authorized, or directed by a Plan Physician and you receive the Services from Plan Providers inside our Southern California Region Service Area (your Home Region), except where specifically noted to the contrary in the *Evidence of Coverage* (*EOC*) for authorized referrals, hospice care, Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, and emergency ambulance Services

Annual Out-of-Pocket Maximum for Certain Services	
For Services subject to the maximum, you will not pay any more Cost Sharing during a calendar year if the Copayments and Coinsurance you pay for those Services add up to one of the following amounts:	
For self-only enrollment (a Family of one Member)	$1,500 per calendar year
For any one Member in a Family of two or more Members	$1,500 per calendar year
For an entire Family of two or more Members	$3,000 per calendar year
Deductible	None
Lifetime Maximum	
Services covered under "Transgender Surgery" in the *EOC*	$75,000
All other Services	None
Professional Services (Plan Provider office visits)	**You Pay**
Most primary and specialty care consultations, exams, and treatment	$20 per visit
Routine physical maintenance exams, including well-woman exams	No charge
Well-child preventive exams (through age 23 months)	No charge
Family planning counseling and consultations	No charge
Scheduled prenatal care exams and first postpartum follow-up consultation and exam	No charge
Eye exams for refraction	No charge
Hearing exams	No charge
Urgent care consultations, exams, and treatment	$20 per visit
Physical, occupational, and speech therapy	$20 per visit
Outpatient Services	**You Pay**
Outpatient surgery and certain other outpatient procedures	$35 per procedure
Allergy injections (including allergy serum)	$5 per visit
Most immunizations (including the vaccine)	No charge
Most X-rays and laboratory tests	No charge
Health education:	
Covered individual health education counseling	No charge
Covered health education programs	No charge
Hospitalization Services	**You Pay**
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	$100 per admission
Emergency Health Coverage	**You Pay**
Emergency Department visits	$100 per visit
Note: This Cost Sharing does not apply if admitted directly to the hospital as an inpatient for covered Services (see "Hospitalization Services" for inpatient Cost Sharing).	
Ambulance Services	**You Pay**
Ambulance Services	No charge
Prescription Drug Coverage	**You Pay**
Covered outpatient items in accord with our drug formulary guidelines:	
Most generic items at a Plan Pharmacy	$5 for up to a 30-day supply, $10 for a 31- to 60-day supply, or $15 for a 61- to 100-day supply
Most generic refills through our mail-order service	$5 for up to a 30-day supply or $10 for a 31- to 100-day supply

Benefit Summary *(continued)*

Most brand-name items at a Plan Pharmacy	$15 for up to a 30-day supply, $30 for a 31- to 60-day supply, or $45 for a 61- to 100-day supply
Most brand-name refills through our mail-order service	$15 for up to a 30-day supply or $30 for a 31- to 100-day supply

Durable Medical Equipment	**You Pay**
Covered durable medical equipment for home use in accord with our durable medical equipment formulary guidelines	No charge

Mental Health Services	**You Pay**
Inpatient psychiatric hospitalization	$100 per admission
Individual outpatient mental health evaluation and treatment	$20 per visit
Group outpatient mental health treatment	$10 per visit

Chemical Dependency Services	**You Pay**
Inpatient detoxification	$100 per admission
Individual outpatient chemical dependency evaluation and treatment	$20 per visit
Group outpatient chemical dependency treatment	$5 per visit

Home Health Services	**You Pay**
Home health care (up to 100 visits per calendar year)	No charge

Other	**You Pay**
Hearing aid(s) every 36 months	Amount in excess of $2,500 Allowance per aid
Skilled nursing facility care (up to 100 days per benefit period)	No charge
Covered external prosthetic devices, orthotic devices, and ostomy and urological supplies	No charge
All Services related to covered conception by artificial means (one treatment cycle per lifetime)	50% Coinsurance
Hospice care	No charge

This is a summary of the most frequently asked-about benefits. This chart does not explain benefits, Cost Sharing, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and Cost Sharing. For a complete explanation, please refer to the *EOC*. Please note that we provide all benefits required by law (for example, diabetes testing supplies).

City & County of San Francisco

Current Office Visit copay going from $20.00 to $25.00	**-0.52%**
Current Outpatient Surgery copay going from $35.00 to $50.00	**-0.01%**

		Decrement
Current RX Plan	**Generic- $5 (30 Day), $10 (100 day), Brand- $15 (30 Day), $30 (100 Day MOI)**	N/A
Option 1	**Generic- $10 (30 Day), $20 (100 day), Brand- $25 (30 Day), $50 (100 Day MOI)**	**-2.08%**
Option 2	**Generic- $5 (30 Day), $10 (100 day), Brand- $25 (30 Day), $50 (100 Day MOI)**	**-0.79%**
Option 3	**Generic- $10 (30 Day), $20 (100 day), Brand- $15 (30 Day), $30 (100 Day MOI)**	**-1.26%**
Option 4	**Generic- $15 (30 Day), $30 (100 day), Brand- $25 (30 Day), $50 (100 Day MOI)**	**-2.59%**

1. Illustrative decrements assume current plan design with only these specific changes.

Please note that decrements are not additive and that if more than one of these options are requested we will have to price all of these plan options together to get a true and accurate rate decrement.

KAISER PERMANENTE®

HSS: Risk Sharing Arrangement *Proposal*

January 1, 2014 – December 31, 2014

Prepared by Strategic Underwriting
Version Date: April 26, 2013

KAISER PERMANENTE

This proposal for a Risk Sharing Arrangement, a form of retrospective experience rating, is between Health Services System and Kaiser Foundation Health Plan, Inc. Northern California Region. This proposal does not constitute an agreement.

Contract Period: 01/01/2014 through 12/31/2014

1. Premium billed, will reflect rates produced under Health Plan's standard rating factors and renewal methodology used for all large commercial groups.
2. Risk corridor:
    a. Risk corridor for surpluses = 25.0% of premium
    b. Risk corridor for deficits = 25.0% of premium
3. Group's risk share within risk corridor is 100%.
4. A risk charge of 0% will be added to the premium for entering into this arrangement.
5. Medical Expense Pooling:
    a. Pooling maximum per member applies at $550,000.
    b. Pooling maximum charge does apply at $10.07 pmpm.
6. Fully insured standard retention rates will apply at $24.97 pmpm.

    The Federal PCORI Fee/Transitional Reinsurance Program Contributions fee is $5.42. The Federal Health Insurer Fee of 0.65% of premium will be applied.
7. Other Benefits:
    a. Chiropractic coverage will be based on the per subscriber billed rates of $1.32/$2.64/$3.74 for the respective Ee/Ee+1/Ee+2 rate tiers.
    b. Hearing coverage will be based on a pmpm charge of $1.80
    c. Additional pmpm charge to be added for surcharge buyout of unassigned members to be determined based on actual 2014 enrollment.
8. Experience period used will be January 1, 2014 Through December 31, 2013.
9. Consolidated Annual Reconciliation:
    a. Health Plan will perform a consolidated retrospective adjustment calculation annually.
    b. The retrospective adjustment calculation will occur after the contract year, comparing earned premium to total expenses. Total expenses include incurred claims with three months of run-out following the experience period (12/15 basis), and adjusted for remaining IBNR, pooling if applicable, plus retention, risk charges, commissions, premium tax, any additional coverages / riders, and alternative payment plan charges if applicable.
    c. If earned premium is greater than total expenses, Kaiser Permanente will refund the difference to Health Service System up to the minimum percent of premium, based on the risk corridor for surpluses stated above, and limited by the group's risk share percent.

d. Conversely, if earned premium is less than total expenses, Health Service System will pay Kaiser Permanente the difference up to the maximum percent of premium based on the risk corridor for deficits stated above, and limited by the group's risk share percent.

10. Health Plan will perform risk sharing arrangement calculations 6-9 months after the end of the experience period.
11. Health Plan or Health Service System will pay the other within 60 days after Health Plan sends notice of the consolidated retrospective adjustment amount.
12. Late payments will accrue beginning 31 days after the due date, at an interest rate of 7.25% per month.
13. RSA will be reconciled annually with payout of all surpluses or collection of deficits. No carry forward provisions – surpluses or deficits will not be credited or debited into future rates.
14. Proposed premium rates to be used for the Risk Sharing Arrangement are shown below:

Actives	
Subscriber Only	$559.07
Subscriber and Spouse	$1,118.14
Subscriber and Spouse and 1 or more children	$1,582.17

Early Retirees	
Subscriber Only	$1,128.63
Subscriber and Spouse	$1,687.70
Subscriber and Family	$2,151.73

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Example Risk Sharing Arrangement Reconciliation

A. Detailed Calculations at the Regional/Product Level

Population/Plan:	NCR DHMO

INCURRED MEDICAL EXPENSES	PMPM	Total
Paid Claims	$ 260.33	$ 2,063,643
Less Run-in	$ (5.26)	$ (41,688)
Claims Paid and Incurred	$ 255.07	$ 2,021,955
Run-Out	$ 4.03	$ 31,941
IBNR	$ 1.12	$ 8,909
Incurred Claims	$ 260.23	$ 2,062,805
- Pooling Credit	$ (30.38)	$ (240,822)
+ Pooling Charge ($125000 Pooling Point)	$ 23.72	$ 188,028
Incurred Claims Net of pooling:	$ 253.57	$ 2,010,011
Other Benefits (Hearing, Dental, Chiro, Optical)	$ 1.15	$ 9,116
Total Incurred Medical Expenses	$ 254.72	$ 2,019,127

ADMINISTRATIVE EXPENSES	PMPM	Total
Retention Charges	$23.32	$ 184,858
Broker Commissions		$ -
Alternative Payment Plan		$ -
Premium Tax		$ -
Risk-Sharing Arrangement Charge (0.650%)	$ 1.57	$ 12,463
Total Administrative Expenses		$ 197,320

TOTAL EXPENSES (Incurred Medical and Administrative)	$ 279.61	$ 2,216,448

EARNED PREMIUM	$ 1,917,361

INITIAL SURPLUS/DEFICIT (Earned Premium Less Total Expenses)	$ (37.72)	$ (299,086)

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B. Consolidated Annual Reconciliation—Surplus Example

POPULATION/PRODUCT SUMMARY

POPULATION/ PRODUCT	INCURRED MEDICAL EXPENSES	ADMINISTRATIVE EXPENSES	TOTAL EXPENSES (Incurred Medical and Administrative)	EARNED PREMIUM	INITIAL SURPLUS/DEFICIT (Earned Premium Less Total Expenses)
NCR DHMO	$2,019,127	$197,320	$2,216,448	$1,917,361	($299,086)
NCR HMO	$5,680,206	$632,346	$6,312,551	$6,805,927	$493,375
Subtotal NCR	$7,699,333	$829,666	$8,528,999	$8,723,288	$194,289
Total	$7,699,333	$829,666	$8,528,999	$8,723,288	$194,289

CONSOLIDATED RECONCILIATION

Upper Risk Corridor Threshold	2.5%
Lower Risk Corridor Threshold	-2.5%
Employer Risk Share	100%
Total Earned Premium	$8,723,288
Maximum Premiums	$8,941,370
Minimum Premiums	$8,505,206
Total Expenses (Incurred Medical and Administrative)	$8,528,999
Earned Premiums Less Total Expenses with Risk Share Applied	$194,289
Maximum Payment (Earned Premiums Less Maximum Premiums)	($218,082)
Maximum Refund (Earned Premiums Less Minimum Premiums)	$218,082
Consolidated Reconciliation Amount (Refund to Group)	$194,289

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C. Consolidated Annual Reconciliation—Deficit Example

POPULATION/PRODUCT SUMMARY					
POPULATION/ PRODUCT	INCURRED MEDICAL EXPENSES	ADMINISTRATIVE EXPENSES	TOTAL EXPENSES (Incurred Medical and Administrative)	EARNED PREMIUM	INITIAL SURPLUS/DEFICIT (Earned Premium Less Total Expenses)
NCR DHMO	$2,019,127	$197,320	$2,216,448	$1,917,361	($299,086)
NCR HMO	$6,257,690	$632,346	$6,890,035	$6,805,927	($84,109)
Subtotal NCR	$8,276,817	$829,666	$9,106,483	$8,723,288	($383,195)
Total	$8,276,817	$829,666	$9,106,483	$8,723,288	($383,195)

CONSOLIDATED RECONCILIATION	
Upper Risk Corridor Threshold	2.5%
Lower Risk Corridor Threshold	-2.5%
Employer Risk Share	100%
Total Earned Premium	$8,723,288
Maximum Premiums	$8,941,370
Minimum Premiums	$8,505,206
Total Expenses (Incurred Medical and Administrative)	$9,106,483
Earned Premiums Less Total Expenses with Risk Share Applied	($383,195)
Maximum Payment (Earned Premiums Less Maximum Premiums)	($218,082)
Maximum Refund (Earned Premiums Less Minimum Premiums)	$218,082
Consolidated Reconciliation Amount (Payment From Group)	($218,082)

KAISER PERMANENTE®

HSS: *Self-Funding Proposal*

January 1, 2014 – December 31, 2014

Prepared by Strategic Underwriting
Version Date: April 26, 2013

KAISER PERMANENTE

Rate Buildup
City & County of San Francisco
January 1, 2014

	Members		45,070
	Subscribers		21,708
	Paid Claims (Fully insured, include OMS and ICM)		$417.88
+	Pooling Credit		-$5.74
+	Pooling Charge		$6.93
=	Paid Claims Net of pooling		$419.07
x	Incurred Claim Adjustment Factor	1.00715	
x	Demographic Change	0.9985	
x	Historical Benefit Change	0.9965	
x	Trend	1.126	
x	Future Benefit Change	1.00000	
=	PMPM		$472.87
x	Average Contract Size	2.07619	
=	PEPM		$991.35
+	Self-Funded Rx per FTC Ruling2		$4.15
=	PEPM Total Claims, OMS, and ICM		$995.50
	Total Projected Incurred Claims, OMS, ICM		**$995.50**
	Administrative Fee		$104.24
	Additional Administrative Services		$0.00
	Administrative Fees - One Time/Setup		$0.00
	Claim Fiduciary Liability (Optional Service)[4]		$0.25
	Transitional Reinsurance Program Contribution		$10.90
	Specific (Individual) Stop Loss - Premium		N/A
	Specifc Stop Loss Expected Recoveries		N/A
	Aggregate Stoploss		N/A
	Miscellaneous Charges		$0.00
	Late Payment Load		N/A
	Broker Fees (Commissions)		$0.00
	Expected Per Employee Per Month Cost		**$1,110.89**

Total Monthly Cost Estimate	$24,115,171
Total Annual Cost Estimate	$289,382,049

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Comparison of Costs - Fully Insured vs. Self Funded
City & County of San Francisco
January 1, 2014

	Illustrative PEPM Fully-Insured	PEPM Self-Funded	Difference
Members		45,070	
Subscribers		21,708	
Projected Incurred Claims and OMS[1]		$855.56	
Self-Funded Rx per FTC Ruling[2]		$4.15	
Projected Incurred Claims, OMS, and Rx	$855.56	$859.71	
Variable Integrated Care Management Medical (	$69.72	$69.72	
Variable Integrated Care Management Pharmac	$25.65	$25.65	
Fixed Integrated Care Management	$40.42	$40.42	
Total Projected Incurred Claims, OMS, ICM	**$991.35**	**$995.50**	**$4.15**
Administrative Fee	$51.85	$104.24	
Additional Administrative Services	$0.00	$0.00	
Administrative Fees - One Time/Setup	$0.00	$0.00	
Claim Fiduciary Liability (Optional Service)[4]	N/A	$0.25	
Premium Tax	$0.00	N/A	
Specific (Individual) Stop Loss - Premium	N/A	N/A	
Specifc Stop Loss Expected Recoveries	N/A	N/A	
Aggregate Stoploss	N/A	N/A	
Miscellaneous Charges	$4.37	$0.00	
Late Payment Load	$0.00	N/A	
Broker Fees (Commissions)	$0.00	$0.00	
Federal PCORI Fee/Transitional Reinsurance P	$11.25	$10.90	
Federal Health Insurer Fee[6]	$6.89	$0.00	
Expected Per Employee Per Month Cost	**$1,065.72**	**$1,110.89**	**$45.17**
Total Monthly Cost Estimate	$23,134,546	$24,115,171	$980,625.24
Total Annual Cost Estimate	$277,614,547	$289,382,049	$11,767,503
Percentage difference			4.24%

KAISER PERMANENTE®

Self-Funded Employer Expected Costs
City & County of San Francisco
January 1, 2014

Members	45,070		
Subscribers	21,708		
Self-Funded Employer Expected Costs	**PMPM**	**PEPM**	**Total $**
Projected Incurred Claims/OMS [1,2]	$414.08	$859.71	$18,662,693
Integrated Care Management- Variable Medical (Proj	$33.58	$69.72	$1,513,396
Integrated Care Management- Variable Pharmacy (Pr	$12.35	$25.65	$556,787
Integrated Care Management- Fixed	$19.47	$40.42	$877,513
Administrative Fee	$50.20	$104.24	$2,262,737
Additional Administrative Services	$0.00	$0.00	$0
Claims Fiduciary (Optional Service)[4]	$0.12	$0.25	$5,427
Administrative Fees - One Time/Setup	$0.00	$0.00	$0
Broker Fees (Commissions)	$0.00	$0.00	$0
Stop Loss Premiums	$0.00	$0.00	$0
Miscellaneous Charges	$0.00	$0.00	$0
Transitional Reinsurance Program Contribution[5]	$5.25	$10.90	$236,618
Self-Funded Employer Expected Variable Costs	$460.01	$955.08	$20,732,876
Self-Funded Employer Expected Fixed Costs	$75.05	$155.81	$3,382,295
Total Self-Funded Employer Expected Costs	**$535.06**	**$1,110.89**	**$24,115,171**

KAISER PERMANENTE

Self-Funded Pricing Assumptions
City & County of San Francisco
January 1, 2014

The fees and other financial terms in this proposal for the Kaiser Permanente self-funded program administered by Kaiser Permanente Insurance Company ("KPIC") (the "Proposal") are based on (1) the terms, conditions and assumptions outlined below; (2) the plan of benefits described in KPIC's RFP response or Plan Sponsor's existing plan of benefits, as noted in this Proposal; (3) demographic and claims data provided by Plan Sponsor in connection with this Proposal, or with respect to existing Kaiser Permanente groups, demographic and claims data in Kaiser Permanente systems as of the date noted in the Proposal; and (4) Plan Sponsor's agreement to KPIC's standard vendor relationships and operating procedures (collectively, the "Assumptions").

1. Start Date: Commencement of ASO Services as if effective January 1, 2014 ("Effective Date").

2. Participation and Contribution Requirements:
•If the Proposal offers total replacement, no more than 25% of Plan Participants (employees) enrolled in Kaiser Permanente self-funded products may live or work outside of any Kaiser Permanente service area.
•75% of all eligible Plan Participants, excluding those waiving coverage due to alternative group coverage, must be enrolled in a Plan Sponsor medical plan.
•Plan Sponsor must contribute at least 50% of the Plan Participant-only cost.

3. Eligibility Requirements: Plan Sponsor's eligibility criteria must include the following:
•All Plan Participants must live or work in a Kaiser Permanente service area to be eligible for the HMO product.
- A dependent must enroll in the same product as the Plan Participant through whom the dependent is eligible, even if the dependent lives outside of a Kaiser Permanente service area.
•Medicare-eligible Plan Participants and dependents are not eligible for the Kaiser Permanente self-funded program.
•Plan Participants must have an employer/employee relationship to Plan Sponsor or to another entity participating in Plan Sponsor's Plan, unless otherwise approved by KPIC.
•Plan Participants must be active, permanent employees, working a minimum of 20 hours per week. Temporary employees and independent contractors are not eligible, unless otherwise noted in the Proposal.

4. Enrollment
•If actual enrollment of Plan Participants in the Kaiser Permanente self-funded program as of the Effective Date differs from the data used to prepare the Proposal, based on any of the measures described below, or if during the Plan year, there are any such changes from the actual enrollment as of the Effective Date, KPIC may modify the fees on notice to Plan Sponsor:
- A +/- 10% change in the total number of Plan Participants enrolled, or in enrollment of Plan Participants by product option.
- COBRA enrollment by Plan Participants is in excess of 10% of total Plan Participant enrollment.
- A +/- 10% change in the number of enrolled Plan Participants who are under age 65 retirees.
- Under age 65 retirees who are enrolled Plan Participants comprise more than 5% of total enrolled Plan Participants.

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5. ASO Services:
•KPIC's standard ASO services include claims administration, customer service, provider network administration, and related services, as described in KPIC's ASO Services Agreement. Such terms provide, without limitation, as follows:
- Integrated Care Management (ICM) services, including, but not limited to Kaiser Permanente health care provider network administration, disease management, health education, utilization management, pharmacy benefit management and nurse-advice services. ICM services cannot be carved out.
- Run-out claims are handled by the prior carrier, unless otherwise noted in proposal.
- Plan Sponsor delegates named claims fiduciary responsibility to Harrington Health, unless otherwise noted in the Proposal.
- Plan Sponsor is responsible for COBRA administration, including enrollment of COBRA eligibles in a COBRA subgroup, unless otherwise noted in the Proposal.
- Standard reporting package is included, unless otherwise noted in the Proposal.

6. Non-Discriminatory Offering:
•Kaiser Permanente's self-funded program must be offered to Plan Participants on conditions that are no less favorable than the conditions applicable to other Plan options offered by Plan Sponsor to Plan Participants. Specifically, and without limitation:
- Kaiser Permanente' s self-funded program must be offered to all eligible Plan Participants, and must be communicated and promoted in the same manner that Plan Sponsor communicates and promotes its other Plan options.
- Kaiser Permanente must be granted access to Plan Participants and Plan Sponsor on the same basis as all other Plan options offered by Plan Sponsor.
- Plan Sponsor' s contribution formula may not disadvantage the Kaiser Permanente self-funding program. Fixed dollar or percentage contributions applicable to all Plan options are acceptable.
- If early retirees are covered, Plan Sponsor must permit enrollment by early retirees in all Plan options on the same basis.
- Eligibility rules, such as dependent age limits and waiting periods for new hires, must be the same for all Plan options offered by Plan Sponsor.

7. Stop-Loss Coverage. Stop loss coverage is required, if quoted in the Proposal, and must be provided through KPIC or another carrier approved by KPIC.
N/A
•Plan Sponsor must complete the attached KPIC Disclosure Statement with claims and enrollment information updated as of 30 days prior to Effective Date. KPIC may modify the stop loss fees and terms in its discretion based on the updated Disclosure Statement.

8. Financial Status
•The Proposal is expressly conditioned on KPIC's assessment of Plan Sponsor's financial status and ability to fund a self-funded program. Plan Sponsor will provide financial information at KPIC's request to permit KPIC to update its assessment from time to time.

9. Changes in Assumptions. Plan Sponsor must notify KPIC of any change in the Assumptions. KPIC may, on written notice to Plan Sponsor and in KPIC's sole discretion, based on changes in the Assumptions, including without limitation, KPIC's assessment of Plan Sponsor's financial status or KPIC's re-evaluation of enrollment or claims data, modify the fees and terms of the Proposal or withdraw the Proposal in its entirety.

10. ACA Taxes
Federal PCORI Fee – A fee per covered life paid by commercial insurers and self-funded plan sponsors to fund the Patient-Centered Outcomes Research Institute (PCORI). PCORI

was established by the Affordable Care Act. The PCORI will commission studies that compare drugs, medical devices, tests, surgeries and ways to deliver health care.
Federal Transitional Reinsurance Program Contribution – A fee paid by commercial insurers and third party administrators for self-funded plans from 2014 through 2016 to support reinsurance to individual market insurers covering high risk individuals in Exchanges.

Federal Health Insurer Fee – A percent of premium fee paid by insurance carriers for commercial and Medicare business beginning January 1, 2014.

Fee Restructure
And
Integrated Care Management

4443

May 9, 2013

KAISER PERMANENTE®

Costs Within an Integrated Delivery System

- KP is an integrated delivery system and its value is driven by the unique way that it delivers care to members (i.e., Permanente Medicine) and its care delivery infrastructure.
- KP is both payer and provider and manages the total cost of care, not just individual pieces.
- The efficiencies from KP's delivery system are reflected in total costs, not any particular line item or calculation in the rating formula.
- KP does not concentrate its efforts on billing for services but rather spend its time taking care of members in the most cost-efficient manner, even if these services are not "billable".
  - Historically, physicians have come to Kaiser Permanente to concentrate on practicing medicine and avoid the administrative hassles of running a medical office (e.g., contracting, coding, billing, collections).
  - At KP, there has been increased focus in leveraging technology to shift care from traditional settings (e.g., office visits) to more effective methods such as e-mails and phone consultations. Additional workflow is necessary to convert these into "billable" services.
  - This results in utilization patterns that are significantly different from competitors in the market.

4444

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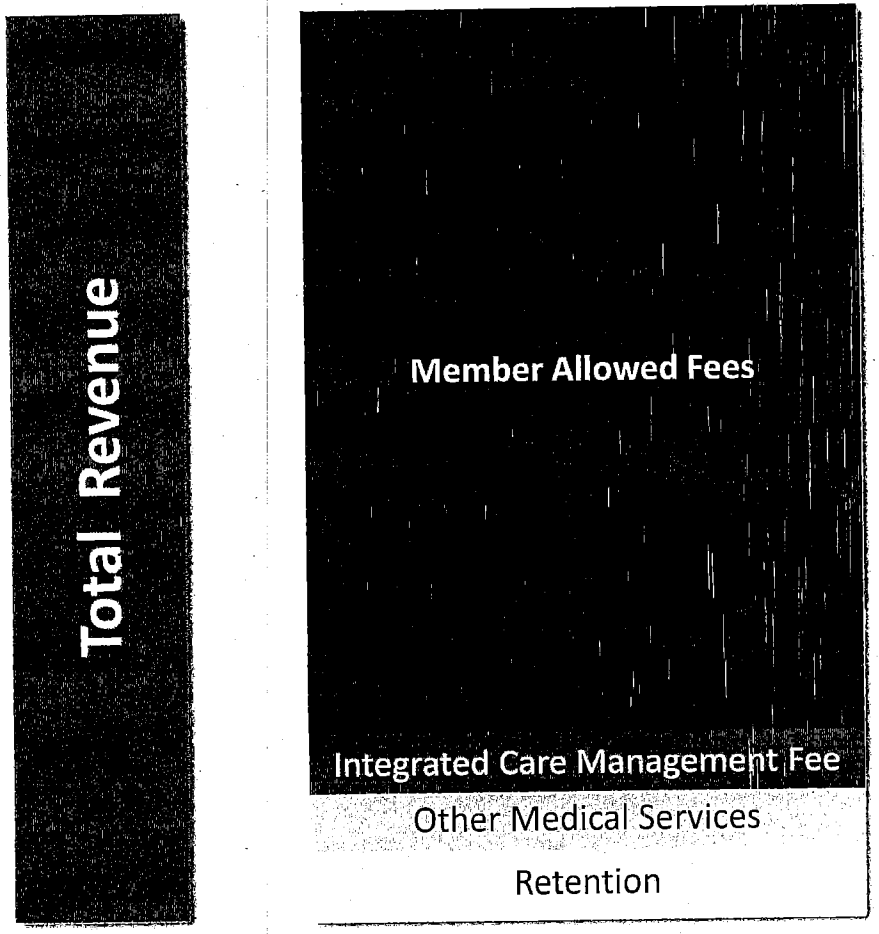
KP Fee Schedule Components



Unit prices for medical services multiplied by member utilization

Fee for integrated care management, including pharmacy management, secure messaging, and nurse line/wellness activities

Billable services not captured/coded

Administrative charge

4445

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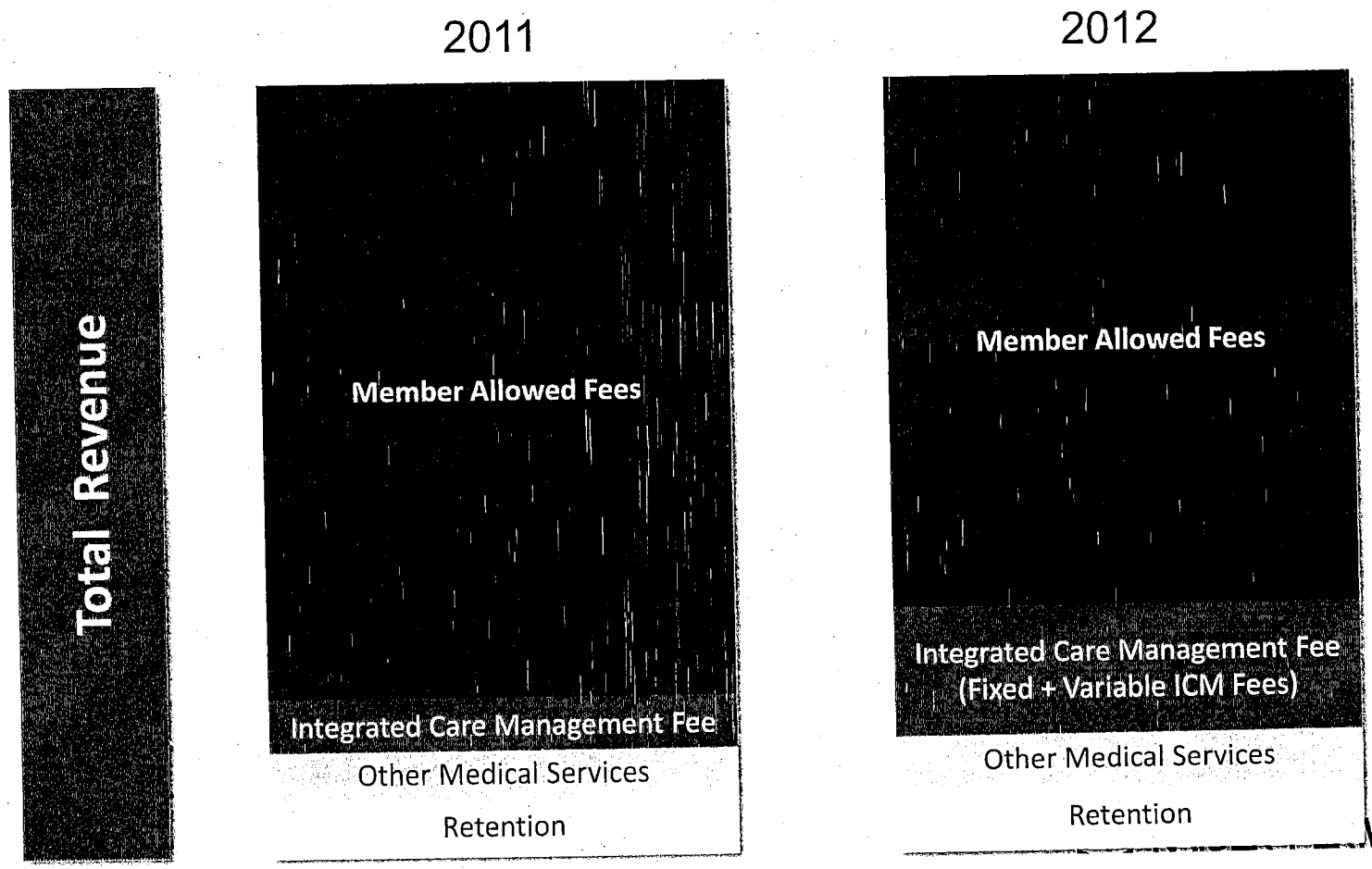
KP Fee Schedule Redesign

Starting in 2012, KP redesigned its fee schedule components so that it more closely aligns with how care is delivered (less "billable" services, more integrated care management services). This was accomplished by lowering member fees and increasing the integrated care management fee (including fixed and variable components).



4446

CCSF vs. KP's Book of Business – 2011 vs. 2012

- The fee schedule redesign can be seen in the comparison of 2011 vs. 2012 claims for CCSF and KP's total book of business. The trend for inpatient and outpatient services (member allowed fees) is negative for both CCSF and KP's book of business while the "Other" category (including OMS/ICM) increased by over 40% for both CCSF and KP's book of business.
- Overall, claims for both CCSF and KP's book of business increased 5.5%, which is consistent with Kaiser's overall commercial rate increase from 2011 to 2012.

4447

CCSF Actives - PMPM

	2011	2012	% Change
Inpatient	$140.40	$136.18	-3.0%
Outpatient	$127.59	$125.68	-1.5%
Pharmacy	$36.30	$39.40	8.5%
Other (Including OMS/ICM)	$56.85	$79.57	40.0%
Total	$361.14	$380.83	5.5%

CCSF Early Retirees - PMPM

	2011	2012	% Change
Inpatient	$315.09	$297.97	-5.4%
Outpatient	$210.68	$215.75	2.4%
Pharmacy	$77.74	$83.56	7.5%
Other (Including OMS/ICM)	$66.12	$130.60	97.5%
Total	$669.63	$727.88	8.7%

Kaiser Permanente Book of Business - PMPM

	2011	2012	% Change
Inpatient	$142.32	$138.23	-2.9%
Outpatient	$131.03	$130.97	0.0%
Pharmacy	$33.27	$34.56	3.9%
Other (Including OMS/ICM)	$54.95	$77.59	41.2%
Total	$361.57	$381.35	5.5%

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What's in IGM?

- External Provider Network Management
- Telephonic Clinical Advice
- Online Personal Health Management
- Clinical Access Alternatives
- Wellness Information & Coaching
- Chronic Condition Management
- Medical / Case Management
- Pharmacy Management

KAISER PERMANENTE®

Clinical Access Alternatives

Application/Service	Description
Secure email correspondence with physician/physician's office	Members can email their doctor's office with nonurgent questions—often saving an appointment and a trip to the medical office, as well as a copay. Most other health plans charge members a copay for electronic messaging, if it's covered at all.
Scheduled phone calls with physicians and staff	Scheduled phone visits with caregivers can save members an office visit.
Electronic specialist consults (doctor to doctor)	E-consults between primary care physicians and specialists help resolve questions or advance treatment before specialist visits. The e-consult enables the primary care physician to order any necessary tests or exams before the member sees the specialist, reducing extra visits and making the care experience more fluid and effective, leading to a quicker result.
Phone specialist consults (primary care physician, member, specialist)	When needed during a member's primary care visit, a physician can call a specialist to evaluate the patient's symptoms and immediately resolve the issue or determine if tests are needed or a specialist visit should be scheduled.
Ongoing specialist-to-primary care physician communication	Following patient evaluations, primary care physicians and specialists can view each other's electronic treatment notes in real time and on an ongoing basis. This allows for a thorough and accurate exchange of information.

4449

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Chronic Conditions Management

Item/Service	Description
Development of evidence-based chronic condition programs	Includes creation/identification of best practices and registry development for our award-winning chronic condition and disease management programs. Programs include: asthma, cancer, coronary heart failure, depression, diabetes, hypertension, chronic pain, chronic obstructive pulmonary disease, coronary artery disease, high-risk maternity, HIV/AIDS, neonatal complications, and obesity. Other health plans contract with third-party disease management vendors with little ability to integrate with the clinical care experience.
Case identification and automatic enrollment	Includes disease registries and built-in system alerts that automatically identify at-risk members. If a chronic condition is diagnosed, the member is automatically enrolled in the appropriate program. Third-party disease management programs aren't connected to the care experience, so patients have to opt in, may require health plan authorization, and may incur additional costs.

4450

KAISER PERMANENTE®

Chronic Conditions Management

ICM Service	Description
Outcomes tracking and analysis	Constant patient monitoring by the entire Kaiser Permanente care team optimizes outcomes for both individuals and populations. Doctors, specialists, nurses, health educators, and lab techs work together, sharing information, protocols, and best practices for better outcomes. The care team is connected by and has access to a single electronic health record, reducing or eliminating care and information gaps. Third-party disease management programs are disconnected from care providers and clinical data—they're usually working from call centers and can only refer to claims data.
Employer reporting and wellness program consultation	Partnership in Health chronic condition reports collect aggregate clinical data, track HEDIS measures and health outcomes, and reveal the prevalence and cost of certain chronic conditions. Recommendations for workforce health improvement—including wellness programs—are provided based on the results. This level of clinical data reporting isn't possible with fee-for-service, fragmented care models.

4451

KAISER PERMANENTE®

Chronic Conditions Management

UCM Service	Description
Member outreach and inreach	Includes patient outreach (by phone, mail, and other collateral) and inreach (via electronic alerts within their electronic health record and face-to-face prompts that occur during patient visits). Proven to increase member adherence to care protocols such as screenings, immunizations, and scheduled tests.
Patient self-care tools and education for chronic conditions	Includes health education classes, online tools and calculators, videos, and brochures that address chronic conditions such as diabetes or asthma.
Digital coaching for chronic conditions	Customized and interactive online programs help members manage their chronic conditions with relevant information around diet, exercise, medication, stress management, and more. Member self-reported data is used to generate aggregate reports on program use and effectiveness.

4452

Pharmacy Management

ICM Service	Description
Discount/rebate negotiation with manufacturers	We leverage our organizational size to negotiate prescription drug prices, helping reduce costs.
Automated refills by phone or online; no additional costs for mail order on all prescriptions; prescription refill email reminders; refill status online; online access to pharmacists	Members can conveniently order prescription refills online 24 hours a day, 7 days a week and have them delivered to their homes at no additional cost—saving time away from work. Refill email reminders help increase pharmacy adherence, improving outcomes. Members can also email questions to a Kaiser Permanente pharmacist anytime.
Formulary development	Our practicing physicians and pharmacists work together to build an evidence-based formulary. This physician-led process results in greater formulary adherence. Also includes research teams that track new FDA drug approvals and analyze studies and comparative prices of existing therapies. We also study member drug outcomes using Kaiser Permanente HealthConnect®—information is shared quickly and efficiently across the organization. And unlike in the fragmented fee-for-service world, pharmaceutical reps are restricted from Kaiser Permanente campuses.

4453

KAISER PERMANENTE®

Pharmacy Management

ICM Service	Description
Physician education	Includes the automatic dissemination of formulary guidelines, medication best practices, safety prompts, and alerts to physicians via our electronic health record system. Also includes dedicated pharmacy educators who work to develop site-specific physician medication education programs.
Patient counseling and education	Includes face-to-face consults and printed instructions for all new and changed prescriptions for members—improving adherence.
Anticoagulation clinic (use of warfarin, also known by brand-name Coumadin)	Refers to clinics specializing in blood thinner treatment for clotting disorders. Physicians refer high-risk patients to pharmacist-led anticoagulation teams to manage status within a narrow therapeutic window. Physician continues to work closely with the pharmacist, supervising and collecting quality data. Established programwide. Our "center of excellence" approach results in high patient volume (700 patients annually vs. 3 to 10 for private practice), which leads to increased expertise and better outcomes (patient risk mortality is 1% at Kaiser Permanente versus the published results of 8 to 12% outside of Kaiser Permanente).

4454

KAISER PERMANENTE®

Online Personal Health Management

ICM Service	Description
Clinically populated personal health record	Member personal health records draw clinical health information in real time from our electronic medical record system, KP HealthConnect. Other health plans may offer personal health records, but they draw information from claims data or rely on members to self-report information. Our clinically based records are populated, shared, and accessed by care team members. Members can also suggest updates to their personal health record information.
After-visit summary	After-visit summaries include treatment plans, physician notes, vitals, and more. Members can review their summaries online anytime.
Rapid posting of lab results	Members can view select lab results online—sometimes the same day the test was taken. Results also show information on why the test was taken and how to interpret results. This feature saves members from having to take time off work to make an office visit or a phone call.
Schedule/manage appointments	Members can request and review routine appointments online, at their convenience, saving a phone call.

4455

KAISER PERMANENTE®

Online Personal Health Management

ICM Service	Description
View allergy treatment/immunization schedules	Members can review their or their children's allergies and immunization histories online instead of relying on paper records. This convenient, time-saving feature especially helps parents of school-age children who must frequently provide proof of immunization status.
View status for recommended preventive screenings	Members can access a list of their recommended or scheduled health screenings. Members also receive electronic health prompts for overdue tests and screenings, increasing adherence and improving health.

4456

Wellness Information and Coaching

ICM Service	Description
Web-based health education content and tools for wellness	Includes **kp.org** clinical content available to members and nonmembers—encyclopedias, videos, virtual tours of our maternity departments, podcasts, featured topics, tools, and calculators target lifestyle-specific risk behaviors such as smoking.
Targeted health and wellness mailings and reminders	Includes mail and phone outreach for preventive care for nonchronic conditions (flu shots, vaccinations, immunizations, health screenings) to help keep members healthy. Outreach comes from the care providers, not the health plan, increasing the importance of the mailing from the member's perspective.
Health education classes and support groups	Covers a wide array of health education classes and peer-support groups conveniently located at Kaiser Permanente facilities. Classes promote preventive care, encourage fitness and nutrition, and support treatment plans.
Health risk assessment tools integrated with care management services	Includes total health assessments, which give members a detailed overview of their lifestyle and health risks and assess their readiness to change. Unlike with other health plans, the results can be added to members' electronic medical record for discussion with their physician.

Wellness Information and Coaching

IC&M service	Description
Newsletter and other health information	Includes our *Partners in Health* member newsletter and health topic–specific communications (e.g., senior health, maternity) in a variety of languages to support culturally competent care.
Telephonic health coaching	One-on-one personal coaching motivates members to establish and meet health goals such as smoking cessation, weight loss, or improved nutrition. Coaches have access to member health records for a total health approach.
Digital coaching for wellness	Interactive and customized, these online programs help members improve their health by addressing a variety of lifestyle risk behaviors. Member self-reported data is used to generate aggregate reports on program use and effectiveness.
Other programs (walking programs, discounted fitness/gym rates)	Includes Thrive Across America℠ fitness program, gym/fitness club discounts, and complementary care programs that support total health.

4458

Telephonic Clinical Advice

ICM Service	Description
Integrated nurse advice and appointment system	Our 24/7 nurse advice line is staffed by Kaiser Permanente nurses with access to member medical records and an available physician to handle more serious calls. With access to clinical data, nurses can triage members more effectively and make appointments when appropriate. They also help members save money by avoiding trips to urgent and emergency care for nonurgent conditions. Other health plans hire nurses with access to claims data and little or no connection to the clinical care experience.

4459

KAISER PERMANENTE®

External Provider Network Management

ICM Service	Description
External provider network building and maintenance	Includes identifying, contracting with, and reviewing external provider networks. The networks are reviewed, approved, and managed by Permanente physician groups in partnership with our health plan to provide clinical oversight. Most other health plan networks are reviewed, approved, and managed by health plan administrators only.
Competitive network discounts	Network rates are negotiated, leveraging volume to achieve competitive discounts where applicable.
Access to discounted affinity networks for complementary medical care	Special rates are negotiated for acupuncture, massage, and chiropractic care.
Arrangements with out-of-area providers	Arrange access and negotiate prices with out-of-area providers that provide care to members on an ad hoc basis (in cases like travel emergencies).
Claims repricing	Includes the processing and negotiation of claims from outside providers.
Access to "center of excellence" networks for transplants and other specialized services	Includes identifying, contracting with, and integrating operations with care centers to effectively support patients in need of highly specialized care.

4460

KAISER PERMANENTE®

Medical Case Management

ICM Service	Description
Evidence-based clinical guidelines	Includes development, vetting, and electronic dissemination of clinical best practices that drive quality and cost-efficiencies. Also includes support for and leveraging of academic research resources and results from our clinical research departments and Care Management Institute. As a result, we can go from cutting-edge knowledge to implementation in just one year—outside of Kaiser Permanente, it can take 17 years for best practices to become standard.
Preadmission review	Includes review of patient medical record prior to hospital admission (labs, imaging, prescriptions, and more). Ensures admission is for the right reasons. A single technology platform—KP HealthConnect—makes the process efficient, seamless, and consistent. Outside of Kaiser Permanente, hospital care is often disconnected from outpatient care, resulting in a lack of care continuity, redundancy in testing/procedures, and patient inconvenience.
Concurrent review	Includes in-hospital physician care provided by specialists like hospitalists and intensivists.
Discharge planning	Includes outpatient visits, instructions, and ordering of post-visit medications.
Hospital and skilled nursing transition programs	Programs staffed by Kaiser Permanente physicians and nurse practitioners help ensure speedy and appropriate transitioning of patients to the right level of care.

Medical Case Management

MCM Service	Description
Case management services (high-intensity/complex case management)	Includes outreach, integration with other care management programs/behavioral health programs, and patient identification triggers and treatment plans for high-need, high-cost patients. Optimizes care and efficiences. Outside of Kaiser Permanente, case coordination is inconsistent—responsibility can be on the primary care physician, hospital, patient, or a health plan case manager who doesn't have ready access to the full medical record.
Transplant cases	Includes identification, transfer, and management of transplant cases. Also includes our internal transplant review board and all pre- and post-care provided by Kaiser Permanente physicians.
Integrated behavioral health/medical case management	Includes depression screening for high-risk members (those with diabetes, coronary artery disease, or congestive heart failure, or pregnant and postpartum women) who complete a total health assessment, and for members with prior depression or suicidal thoughts. Also includes coordination of inpatient transfers to the appropriate case worker or psychiatrist if more serious. Kaiser Permanente behaviorists and social workers are integrated within our care delivery system, working closely with primary care and medical case management teams to help ensure timely, immediate, continuous care, improved outcomes, and lower costs.

Medical Case Management

IcM Service	Description
Quality assurance and management	Includes internal utilization management and physician peer review to drive better, more cost-efficient outcomes. Physician peer review includes system reviews, which address systems issues and help doctors practice better medicine. Outside of Kaiser Permanente, physician peer review is inconsistent and not as widespread, if it exists at all.
Systems support, including case tracking	Includes non-chronic condition (such as maternity, cancer, and allergy care) and orthopedic implant health registries used to identify care and medication gaps. Technology increases safety and interaction control and enables an overall view of the member's health.
Referral management	Includes Permanente Medical Group prospective review and approval of care outside the Kaiser Permanente network.
Emergency prospective review *program (Emergency Department repatriation)*	Kaiser Permanente Emergency Department physicians coordinate with outside *Emergency Departments to provide critical and potentially lifesaving member health information. This helps ensure the safe and timely return of the member to Kaiser Permanente facilities, optimizing care and reducing costs. Outside of Kaiser Permanente, patient medical histories (such as medications and previous tests) are often unavailable to the treating physicians.*

4463

Medical Case Management

ICM Service	Description
Palliative care	Kaiser Permanente works to support patients and their families through a team-based approach that creates the best access to people who are specially trained to provide care in the last stages of life. Outside of Kaiser Permanente, it's very difficult to create a consistent level of support. Some health plans reimburse for services, but when there are no community-based services, offer little real benefit to members.

4464

KAISER PERMANENTE®

CPT Code	Description	2011	2012	Difference
Office visits				
99201	New patient visit, level 1 (low severity)	$60.00	$55.00	($5.00)
99202	New patient visit, level 2	$95.00	$90.00	($5.00)
99203	New patient visit, level 3	$130.00	$130.00	$0.00
99204	New patient visit, level 4	$195.00	$195.00	$0.00
99205	New patient visit, level 5 (high severity)	$250.00	$245.00	($5.00)
99211	Established patient visit, level 1 (low severity)	$40.00	$25.00	($15.00)
99212	Established patient visit, level 2	$60.00	$55.00	($5.00)
99213	Established patient visit, level 3	$85.00	$85.00	$0.00
99214	Established patient visit, level 4	$125.00	$130.00	$5.00
99215	Established patient visit, level 5 (high severity)	$175.00	$175.00	$0.00
Office visits (preventive)				
99381	Well-baby office visit, new patient (under 1 year)	$130.00	$120.00	($10.00)
99382	Well-child office visit, new patient (1-4 years)	$140.00	$130.00	($10.00)
99383	Well-child office visit, new patient (5-11 years)	$145.00	$130.00	($15.00)
99384	Well-child office visit, new patient (12-17 years)	$155.00	$140.00	($15.00)
99385	Well-adult office visit, new patient (18-39 years)	$170.00	$140.00	($30.00)
99386	Well-adult office visit, new patient (40-64 years)	$190.00	$160.00	($30.00)
99387	Well-adult office visit, new patient (65 and older)	$215.00	$180.00	($35.00)
99391	Well-baby office visit, established patient (under 1 year)	$105.00	$100.00	($5.00)
99392	Well-child office visit, established patient (1-4 years)	$115.00	$110.00	($5.00)
99393	Well-child office visit, established patient (5-11 years)	$115.00	$110.00	($5.00)
99394	Well-child office visit, established patient (12-17 years)	$125.00	$120.00	($5.00)
99395	Well-adult office visit, established patient (18-39 years)	$130.00	$120.00	($10.00)
99396	Well-adult office visit, established patient (40-64 years)	$160.00	$135.00	($25.00)
99397	Well-adult office visit, established patient (65 and older)	$180.00	$150.00	($30.00)
Emergency visits				
99282	Emergency care by physician, level 1 (low severity)	$120.00	$120.00	$0.00
99283	Emergency care by physician, level 2	$175.00	$175.00	$0.00
99284	Emergency care by physician, level 3	$255.00	$255.00	$0.00
99285	Emergency care by physician, level 4 (high severity)	$385.00	$385.00	$0.00
Psychotherapy visits				
90853	Group psychological therapy	$80.00	$50.00	($30.00)

90862	Managing mental health drugs	$89.00	$95.00	$6.00
90806	Therapy	$156.00	$135.00	($21.00)
Eye examinations				
92002	Eye exam, routine visit, new patient	$115.00	$126.00	$11.00
92004	Eye exam and treatment, new patient	$193.00	$233.00	$40.00
92012	Eye exam, routine visit, established patient	$115.00	$135.00	$20.00
92014	Eye exam and treatment, established patient	$168.00	$194.00	$26.00
99173	Vision screening test	$9.00	$5.00	($4.00)
Hearing services				
92557	Comprehensive audiometry evaluation	$90.00	$67.00	($23.00)
69210	Ear cleaning	$95.00	$76.00	($19.00)
92567	Eardrum test	$40.00	$26.00	($14.00)
92551	Hearing Screening test (pure tone, air only)	$24.00	$21.00	($3.00)
Physical therapy services				
97014	Electric stimulation therapy, treatment only	$28.00	$24.00	($4.00)
97001	Physical therapy evaluation	$109.00	$119.00	$10.00
97010	Physical therapy hot and cold application, treatment only	$14.00	$9.00	($5.00)
97035	Physical therapy, ultrasound, treatment only	$24.00	$19.00	($5.00)
97110	Physical therapy exercises, treatment only	$45.00	$50.00	$5.00
Vaccines and other injections				
95115	Allergy shot	$25.00	$20.00	($5.00)
90716	Chickenpox vaccine	$98.00	$94.00	($4.00)
90702	Diphtheria, tetanus booster vaccine	$30.00	$27.00	($3.00)
90701	Diphtheria, tetanus, pertussis vaccine	$36.00	$35.00	($1.00)
90658	Flu shot, children (3 years and older)	$20.00	$20.00	$0.00
90657	Flu shot, infants	$16.00	$9.00	($7.00)
90746	Hepatitis B vaccine	$108.00	$88.00	($20.00)
90707	Measles, mumps, and rubella vaccine	$59.00	$64.00	$5.00
90669	Pneumococcal vaccine	$138.00	$141.00	$3.00
90713	Polio vaccine	$33.00	$36.00	$3.00
90706	Rubella vaccine	$28.00	$35.00	$7.00
96372	THER/PROPH/DIAG INJ, SC/IM	$45.00	$40.00	($5.00)
96373	THER/PROPH/DIAG INJ, IA	$40.00	$33.00	($7.00)
Tests and procedures				

94010	Breathing capacity test	$70.00	$60.00	($10.00)
94640	Breathing treatment	$30.00	$29.00	($1.00)
45384	Colonoscopy and removal of abnormal tissue using cautery	$928.00	$714.00	($214.00)
45385	Colonoscopy and removal of abnormal tissue using snare technique	$1,061.00	$814.00	($247.00)
45380	Colonoscopy and removal of colon tissue for examination	$857.00	$726.00	($131.00)
45378	Diagnostic colonoscopy	$640.00	$605.00	($35.00)
45300	Diagnostic proctosigmoidoscopy	$128.00	$178.00	$50.00
45330	Diagnostic sigmoidoscopy	$247.00	$216.00	($31.00)
20610	Draining fluid from around swollen joint	$128.00	$117.00	($11.00)
93000	EKG	$45.00	$35.00	($10.00)
59025	Fetal monitoring	$100.00	$70.00	($30.00)
17003	Removal of abnormal areas of skin	$15.00	$11.00	($4.00)
45331	Sigmoidoscopy and removal of tissue for examination	$276.00	$269.00	($7.00)
11100	Skin biopsy	$150.00	$159.00	$9.00
93015	Stress test	$210.00	$160.00	($50.00)
17000	Surgically destroying an abnormal area of skin	$86.00	$124.00	$38.00
93307	Ultrasound test of heart	$360.00	$260.00	($100.00)
X-rays, CT scans and other imaging studies				
71260	CT scan of chest, including dye	$734.00	$632.00	($102.00)
72193	CT scan of pelvis, including dye	$707.00	$598.00	($109.00)
72192	CT scan of pelvis, without dye	$615.00	$492.00	($123.00)
70470	CT scan of sinus and nasal passages	$739.00	$629.00	($110.00)
74160	CT scan of stomach area with dye	$715.00	$679.00	($36.00)
74150	CT scan of stomach area, without dye	$610.00	$499.00	($111.00)
77056	Mammogram	$242.00	$218.00	($24.00)
77055	Mammogram (one side)	$190.00	$170.00	($20.00)
77057	Mammogram (screening)	$185.00	$159.00	($26.00)
76805	Pregnancy ultrasound	$253.00	$289.00	$36.00
70450	Review of CT scan of the head or brain	$490.00	$400.00	($90.00)
76645	Ultrasound of breast	$154.00	$178.00	$24.00
76856	Ultrasound of pelvis	$225.00	$251.00	$26.00
76700	Ultrasound of stomach area	$253.00	$272.00	$19.00
76830	Vaginal ultrasound	$225.00	$252.00	$27.00
77080	X-ray for osteoporosis	$236.00	$194.00	($42.00)

74022	X-ray of abdomen (complete)	$92.00	$97.00	$5.00
73600	X-ray of ankle	$58.00	$57.00	($1.00)
73610	X-ray of ankle (complete)	$63.00	$65.00	$2.00
73565	X-ray of both knees	$58.00	$68.00	$10.00
71020	X-ray of chest	$75.00	$62.00	($13.00)
71010	X-ray of chest (one view interpretation)	$60.00	$45.00	($15.00)
73140	X-ray of finger	$46.00	$63.00	$17.00
73620	X-ray of foot	$58.00	$55.00	($3.00)
73630	X-ray of foot (complete)	$63.00	$64.00	$1.00
73120	X-ray of hand	$58.00	$55.00	($3.00)
73130	X-ray of hand (complete)	$63.00	$64.00	$1.00
73510	X-ray of hip	$76.00	$77.00	$1.00
73560	X-ray of knee	$63.00	$61.00	($2.00)
73564	X-ray of knee (complete)	$83.00	$84.00	$1.00
72100	X-ray of lower back bones	$81.00	$81.00	$0.00
72050	X-ray of neck	$114.00	$106.00	($8.00)
72040	X-ray of neck bones	$83.00	$78.00	($5.00)
73030	X-ray of shoulder	$76.00	$61.00	($15.00)
74000	X-ray of stomach area (one view)	$66.00	$49.00	($17.00)
73110	X-ray of wrist (complete)	$63.00	$74.00	$11.00
73100	X-ray of wrist (two views)	$60.00	$60.00	$0.00
Laboratory tests				
82040	Albumin test	$13.00	$12.00	($1.00)
84075	Alkaline phosphatase test	$15.00	$12.00	($3.00)
86003	Allergy test	$14.00	$12.00	($2.00)
84460	ALT test	$14.00	$13.00	($1.00)
82150	Amylase test	$20.00	$15.00	($5.00)
84450	AST test	$14.00	$12.00	($2.00)
82247	Bilirubin test (total)	$13.00	$12.00	($1.00)
86592	Blood antibody test	$10.00	$10.00	$0.00
85610	Blood clotting test	$13.00	$9.00	($4.00)
82947	Blood-sugar test, diagnostic	$14.00	$9.00	($5.00)
83036	Blood-sugar test, monitoring	$26.00	$23.00	($3.00)
82310	Calcium test (total)	$13.00	$12.00	($1.00)

82465	Cholesterol level test	$12.00	$10.00	($2.00)
85025	Complete blood count	$20.00	$19.00	($1.00)
82565	Creatinine test	$13.00	$12.00	($1.00)
87340	Hepatitis B surface antigen test	$30.00	$25.00	($5.00)
86803	Hepatitis C test	$31.00	$34.00	$3.00
84520	Kidney function test	$12.00	$9.00	($3.00)
82550	Laboratory chemistry test for creatine kinase	$16.00	$16.00	$0.00
80061	Lipid Panel Test	$35.00	$32.00	($3.00)
83735	Magnesium test	$17.00	$16.00	($1.00)
88150	Pap test, cervical cancer screening	$29.00	$25.00	($4.00)
84100	Phosphorus test	$13.00	$11.00	($2.00)
84132	Potassium test	$14.00	$11.00	($3.00)
84703	Pregnancy test	$24.00	$18.00	($6.00)
84153	Prostate test	$48.00	$44.00	($4.00)
84295	Sodium test	$13.00	$11.00	($2.00)
87650	Strep-A-Swab test	$52.00	$48.00	($4.00)
82270	Test for blood in stool	$9.00	$8.00	($1.00)
87621	Test for genital warts	$92.00	$84.00	($8.00)
84443	Thyroid stimulating hormone test	$47.00	$40.00	($7.00)
87086	Urine bacteria colony count	$23.00	$19.00	($4.00)
81000	Urine test (complete)	$7.00	$8.00	$1.00
81003	Urine test (dip stick only)	$7.00	$5.00	($2.00)
81015	Urine test (microanalysis only)	$6.00	$7.00	$1.00

City and County of San Francisco

Kaiser Permanente Book of Business - PMPM

	10/10-09/11	10/11-09/12	% Change
Inpatient	$142.74	$138.24	-3.2%
Outpatient	$130.95	$130.37	-0.4%
Pharmacy	$33.16	$34.56	4.2%
Other	$54.84	$72.39	32.0%
Total	$361.69	$375.56	3.8%

CCSF Actives - PMPM

	10/10-09/11	10/11-09/12	% Change
Inpatient	$139.07	$134.67	-3.2%
Outpatient	$129.35	$123.87	-4.2%
Pharmacy	$36.22	$39.09	7.9%
Other	$57.00	$74.04	29.9%
Total	$361.64	$371.67	2.8%

CCSF Early Retirees - PMPM

	10/10-09/11	10/11-09/12	% Change
Inpatient	$315.53	$299.62	-5.0%
Outpatient	$208.29	$213.33	2.4%
Pharmacy	$74.89	$84.22	12.5%
Other	$67.01	$115.24	72.0%
Total	$665.72	$712.41	7.0%

the other fee schedule components (namely, the member fees themselves) to deliver the same 2012 rate increase.
    - As you can see, Kaiser opted to redesign its fee schedule components to more closely resemble how Kaiser delivers integrated care (as Dr. Klinger explained in our meeting) rather than on the member prices for coded, billable-type services.
- The best way to understand the changes specific to CCSF would be to compare it relative to the changes in our health plan. See the attached file.
    - CCSF's year over year increase in PMPMs is only 2.8% which is still trending more favorably relative to our health plan for its active population. This is somewhat offset by the higher trends in the early retiree population. Overall, CCSF is trending slightly favorable compared to our health plan.
- In terms of projected increases, the best way to project is to look at how a specific group is trending relative to our health plan (if the group is trending higher, they will likely receive a higher than average rate increase).

Hope this helps. Please let me know if you have any questions. I'm happy to assist the team in preparing explanations for the HSS Board about the way Kaiser develops its rates. Thanks.

Andrew L. See, FSA, MAAA
Vice President, Pricing
Kaiser Foundation Health Plan, Inc.
300 Lakeside Drive, 28th Floor
Oakland, CA 94612
Phone: 510-271-5618
Fax: 510-271-6495

Assistant: Doreen Amarsingh
Phone: 510-268-4402
Doreen.Amarsingh@kp.org

CCSF ICM.xlsx

Gabe Briggs Hi Andrew, It was nice meeting you last week. A... 04/08/2013 11:19:26 AM

From: Gabe Briggs <gabe.briggs@aonhewitt.com>
To: Andrew L See/CA/KAIPERM@KAIPERM
Cc: Raul Monares/PO/KAIPERM@Kaiperm, Anil P Kochhar <anil.kochhar@aonhewitt.com>
Date: 04/08/2013 11:19 AM
Subject: Reconciliation of ICM Fees

Hi Andrew,

It was nice meeting you last week. Anil asked me to send you our reconciliation schedules. What we're trying to do is come up with some simple reconciliation to present to the Board where we tie out the increase in the ICM with reductions in other cost buckets. It may be that we can't do this, however, we'd like to make some kind of attempt. Right now, what we understand is that the ICM went from $27.12 for the experience period Oct. 2010 through Sept. 2011 to a fixed of $20.35 and a variable of $27.22 for the experience period Oct. 2011 through Sept. 2012. The difference between these two

amounts is $20.45. We note that the outpatient pmpm for the same experience periods has reduced from $129.35 to $123.87 for a reduction of $5.48. When we net this against our $20.45, the net is $14.97 (this may be a rather simplified approach). Our problem is we can't explain any of the $14.97. We are looking to you to help us build a schedule that you are comfortable with that can tie out the $20.45. We really appreciate your help. Attached are our first pass reconciliation schedules for actives and early retirees.

Thanks,

Gabe Briggs | Actuarial Analyst
Aon Hewitt | Health and Benefits Consulting
199 Fremont Street, Suite 1500 | San Francisco, CA 94105
tel +1.415.486.6948
gabe.briggs@aonhewitt.com | aonhewitt.com

[attachment "Reconciliation of the ICM fees.xlsx" deleted by Andrew L See/CA/KAIPERM]

FILE NO. 130653

FORM SFEC-126:
NOTIFICATION OF CONTRACT APPROVAL
(S.F. Campaign and Governmental Conduct Code § 1.126)

City Elective Officer Information *(Please print clearly.)*	
Name of City elective officer(s): **Members, San Francisco Board of Supervisors**	City elective office(s) held: **Members, San Francisco Board of Supervisors**

Contractor Information *(Please print clearly.)*

Name of contractor:

Kaiser Foundation Health Plan, Inc.
Northern California Region

Kaiser Foundation Health Plan, Inc.
Southern California Region

Please list the names of (1) members of the contractor's board of directors; (2) the contractor's chief executive officer, chief financial officer and chief operating officer; (3) any person who has an ownership of 20 percent or more in the contractor; (4) any subcontractor listed in the bid or contract; and (5) any political committee sponsored or controlled by the contractor. Use additional pages as necessary.

1.) Please see attached
2.) Please see attached
3.) Kaiser Permanente represents a not-for-profit prepaid group practice plans, which represents a partnership between Kaiser Foundation Health Plan, Inc. and Kaiser Foundation Hospitals and the Permanente Medical Groups. As such, there is no owner, shareholders or sponsor.

    Health Plans and Hospitals are nonprofit corporations whose capital is available for charitable, educational, research and related purposes and are generally exempt from federal and state income taxes. No individual or entity has any ownership interest in Health Plans or Hospitals.

4.) N/A
5.) N/A

Contractor address:

Kaiser Foundation Health Plan, Inc.
Northern California Region
1950 Franklin Street
Oakland, CA 94612

Kaiser Foundation Health Plan, Inc.
Southern California Region
393 East Walnut Street
Pasadena, CA 91188

Date that contract was approved:	Amount of contract: **$322,767,000.00 (calendar year 2014)***

Describe the nature of the contract that was approved: Medical Health Insurance: Kaiser Permanente Traditional Plan, HMO and Senior Advantage with Part D.
Comments: *The amount of this contract is based on the most recent actuarial information and will change due to employee resignations, new hires, terminations and other attrition factors, as well as member selections at the time of qualifying events.

This contract was approved by (check applicable):

☐ the City elective officer(s) identified on this form

☐ a board on which the City elective officer(s) serves San Francisco Board of Supervisors
Print Name of Board

☐ the board of a state agency (Health Authority, Housing Authority Commission, Industrial Development Authority Board, Parking Authority, Redevelopment Agency Commission, Relocation Appeals Board, Treasure Island Development Authority) on which an appointee of the City elective officer(s) identified on this form sits

Print Name of Board

Filer Information *(Please print clearly.)*	
Name of filer: Angela Calvillo, Clerk of the Board	Contact telephone number: (415) 554-5184
Address: City Hall, Room 244 1 Dr. Carlton B. Goodlett Place, San Francisco, CA 94102	E-mail: Board.of.Supervisors@sfgov.org

Signature of City Elective Officer (if submitted by City elective officer) Date Signed

Signature of Board Secretary or Clerk (if submitted by Board Secretary or Clerk) Date Signed

George C. Halvorson
Chairman and Chief Executive Officer, Kaiser Foundation Health Plan, Inc., and Kaiser Foundation Hospitals

Christine K. Cassel, MD, MACP
President and Chief Executive Officer of the American Board of Internal Medicine and ABIM Foundation

Thomas W. Chapman, MPH, EdD
President and Chief Executive Officer of the HSC Foundation

Daniel P. Garcia
Senior Vice President and Chief Compliance Officer, Kaiser Foundation Health Plan, Inc., and Kaiser Foundation Hospitals

William R. Graber
Retired Chief Financial Officer of McKesson Corporation

J. Eugene Grigsby III, PhD
President and Chief Executive Officer of the National Health Foundation

Judith A. Johansen, JD
President of Marylhurst University, Portland, Oregon

Kim J. Kaiser
Senior Pilot, Alaska Airlines

Philip A. Marineau
Operating Partner, LNK Partners, and Retired President and Chief Executive Officer of Levi Strauss & Co.

Jenny J. Ming
President and Chief Executive Officer, Charlotte Russe Holding, Inc., and Former President of Old Navy

Edward Pei
Retired Executive Vice President of the Consumer Banking Group of First Hawaiian Bank

J. Neal Purcell
Retired Vice Chairman and Managing Partner of KPMG, LLP

Cynthia A. Telles, PhD
Director of the Spanish-Speaking Psychosocial Clinic of the Neuropsychiatric Institute and Hospital at the University of California, Los Angeles School of Medicine, and Associate Clinical Professor with the UCLA School of Medicine

Sandra P. Thompkins, JD
Executive Director of Human Resources, Delphi Corporation's Packard Electric Division

■National leadership team

George C. Halvorson
Chairman and Chief Executive Officer

Bernard J. Tyson
Executive Vice President, Health Plan and Hospital Operations

Anthony Barrueta
Senior Vice President, Government Relations

Raymond J. Baxter, PhD
Senior Vice President, Community Benefit, Research and Health Policy

Chuck Columbus
Senior Vice President and Chief Human Resources Officer

Phil Fasano
Executive Vice President and Chief Information Officer

Diane Gage Lofgren, APR
Senior Vice President, Brand Strategy, Communications and Public Relations

Kathy Lancaster
Executive Vice President and Chief Financial Officer

Jed Weissberg, MD
Senior Vice President, Quality and Care Delivery Excellence

Arthur M. Southam, MD
Executive Vice President, Health Plan Operations

Mark S. Zemelman
Senior Vice President and General Counsel

FILE NO. 130653

FORM SFEC-126:
NOTIFICATION OF CONTRACT APPROVAL
(S.F. Campaign and Governmental Conduct Code § 1.126)

City Elective Officer Information *(Please print clearly.)*	
Name of City elective officer(s): **Members, San Francisco Board of Supervisors**	City elective office(s) held: **Members, San Francisco Board of Supervisors**

Contractor Information *(Please print clearly.)*

Name of contractor:
Blue Shield of California

Please list the names of (1) members of the contractor's board of directors; (2) the contractor's chief executive officer, chief financial officer and chief operating officer; (3) any person who has an ownership of 20 percent or more in the contractor; (4) any subcontractor listed in the bid or contract; and (5) any political committee sponsored or controlled by the contractor. Use additional pages as necessary.

(1) members of the contractor's board of directors:

- Paul Markovich
- Doug Busch
- Evelyn Dilsaver
- Hector Flores, M.D.
- Alan Fohrer
- William Hauck
- Sandra Hernandez, M.D.
- Leon E. Panetta
- Robert Lee
- Mohammad H. Qayoumi, Ph.D.

(2) the contractor's chief executive officer, chief financial officer and chief operating officer;

Paul Markovick, President & CEO

Janet Widmann, Executive Vice President, Markets

(3) any person who has an ownership of 20 percent or more in the contractor;

Blue Shield is a Not-for-Profit Mutual Benefit Corporation.

(4) any subcontractor listed in the bid or contract; and

Blue Shield currently contracts with the following vendors to provide cost-effective, quality healthcare services:

- **Accent Company, Omaha, NE (2003)** – Accent provides investigation and recovery functions related to workers' compensation and third-party liability.
- **ACS Commercial Solutions Inc., Sandy, UT (2011)** – ACS provides member enrollment data entry services.
- **Aegis USA, Inc., Los Angeles, CA (2007)** – Aegis assists with handling calls from Individual and Family Plan (IFP) members as well as eligibility and billing questions for members with portfolio plans.
- **Alere, Waltham, MA (2003)** – Alere currently administers Blue Shield's Predictive Triage Engine, disease management programs; a suite high-risk case management programs; chronic complex, prenatal, and musculoskeletal case management programs; tobacco cessation services as part of our Tobacco Cessation program; CareTips clinical care gap messaging for members and providers; and our NurseHelp 24/7 program.
- **American Specialty Health Plans, San Diego, CA (1994)** – American Specialty Health Plans provides access to their chiropractic, acupuncture, and podiatry networks.
- **Argus Health Systems, Kansas City, MO (1999)** – Argus Health Systems provides claims processing for pharmacy benefits. Blue Shield provides pharmacy benefit management, pharmacy network, formulary, prior authorization, and member services internally.
- **Citi Prepaid Services, Conshohocken, PA (2008)** – Citi Prepaid Services (formerly known as eCount) manages the financial incentives linked to our wellness offerings via a prepaid debit card that can be electronically reloaded when additional rewards are earned and redeemed.
- **Curascript, Orlando, FL and CVS Caremark, Woonsocket, RI (since 2005)** – Curascript and CVS Caremark provides specialty pharmacy services.
- **Dental Benefit Providers, Columbia, MD (1988)** – Dental Benefit Providers serves as Blue Shield's dental plan administrator.
- **DST Output, El Dorado Hills, CA (2002)** – DST Output provides production services for ID cards and explanation of benefits documents.
- **Electronic Data Systems, Plano, TX (2001)** – Electronic Data Systems (EDS) provides information systems and reporting services.
- **HealthEquity, Draper, UT (2012)** – HealthEquity provides integrated HSA/HRA/FSA consumer directed healthcare services for our high deductible health plans (HDHP).
- **Healthrageous, Inc., Boston, MA (2012)** – Healthrageous offers a wellness platform that uses wireless-enabled fitness devices and apps to power team challenges among employee populations.
- **Healthwise, Boise, ID (2005)** – Healthwise, a nonprofit consumer health content provider, supplies a robust health and wellness knowledgebase product for use on our website, www.blueshieldca.com.
- **Hinduja Global Solutions Inc., Warrenville, IL. (2011)** – Hinduja provides claims edit resolution services.
- **LabCorp, Burlington, NC (1997)** – LabCorp provides access to a national network of clinical laboratories.
- **Language Line, Monterey, CA (2002)** – Language Line provides language services to assist non-English speaking members.
- **Magellan Health Services, Avon, CT (2012)** – Magellan Health Services serves as Blue Shield's Mental Health Service Administrator (MHSA), providing mental health/substance

abuse network administration, claims, customer service, care management, and medical management. Additionally, they administer our LifeReferrals 24/7 program and a Behavioral Health Depression Management Program that integrates with our disease management program.

- **Medical Eye Services, Santa Ana, CA (1984)** – Medical Eye Services serves as Blue Shield's vision plan administrator.
- **National Imaging Associates, Columbia, MD (1999)** – National Imaging Associates provides prior authorization and medical management for outpatient radiology services, including CAT scans, MRIs/MRAs, nuclear cardiology, bone densitometry, and PET scanning.
- **PrimeMail, Eagan, MN (2008)** – PrimeMail provides mail service for pharmacy benefits. Blue Shield provides pharmacy benefit management, pharmacy network, formulary, prior authorization, and member services internally.
- **Quest Diagnostics, Madison, NJ (2008)** – Quest Diagnostics has provided onsite and remote biometric screening services for Blue Shield clients since 2008. In this time, Quest has staffed multiple events for several different clients and collected biometric data on thousands of employees.
- **SourceHOV, LLC, Dallas, TX. (2007)** – SourceHOV provides paper claims and correspondence mailroom, imaging and data entry services, including image viewing capabilities, claims edit resolution, correspondence activation, small group enrollment, claim credit backs, and pre-denial audits.
- **Summit Health, Chambersburg, PA (2010)** – Summit Health provides onsite and remote biometric screening services for our Shield Wellcheck program, and other onsite wellness services, including immunizations, onsite seminars, lifestyle management courses, ad hoc screening, and tests for our Onsite Wellness program.
- **TeleTech Financial Services Management, LLC, Englewood, CO (2001)** – TeleTech assists with handling phone calls for IFP members, eligibility and billing questions for members with portfolio plans, and providers.
- **WebMD, New York, NY (2008)** – WebMD provides the platform and content for our award-winning online wellness program, Healthy Lifestyle Rewards, and our telephonic Health Coach program.

Please note that Blue Shield providers are neither agents nor employees of the plan but are independent contractors. Blue Shield cannot be held liable for the negligence, wrongful acts or omissions of any person receiving or providing services, including any physician, hospital or other provider.

(5) any political committee sponsored or controlled by the contractor.

EmPAC

Contractor address: 50 Beale Street, San Francisco CA 94105	
Date that contract was approved:	Amount of contract: $ 279,094,000 (flex-funded benefit) + $29,362,000

	(Fully Insured MAPD/COB product)=308,456,000.00
Describe the nature of the contract that was approved: Medical Coverage: Blue Shield Flex Funded HMO for Actives and Early Retirees, and MAPD/COB for Retirees.	
Comments: *The amount of this contract is based on the most recent actuarial information and will change due to employee resignations, new hires, terminations and other attrition factors, as well as member selections at the time of qualifying events.	

This contract was approved by (check applicable):

☐ the City elective officer(s) identified on this form

☐ a board on which the City elective officer(s) serves San Francisco Board of Supervisors
Print Name of Board

☐ the board of a state agency (Health Authority, Housing Authority Commission, Industrial Development Authority Board, Parking Authority, Redevelopment Agency Commission, Relocation Appeals Board, Treasure Island Development Authority) on which an appointee of the City elective officer(s) identified on this form sits

Print Name of Board

Filer Information (*Please print clearly.*)	
Name of filer: Angela Calvillo, Clerk of the Board	Contact telephone number: (415) 554-5184
Address: City Hall, Room 244 1 Dr. Carlton B. Goodlett Place, San Francisco, CA 94102	E-mail: Board.of.Supervisors@sfgov.org

Signature of City Elective Officer (if submitted by City elective officer) Date Signed

Signature of Board Secretary or Clerk (if submitted by Board Secretary or Clerk) Date Signed

S:\ALL FORMS\2008\Form SFEC-126 Contractors doing business with the City 11.08.doc

FILE NO. 130653

FORM SFEC-126:
NOTIFICATION OF CONTRACT APPROVAL
(S.F. Campaign and Governmental Conduct Code § 1.126)

City Elective Officer Information *(Please print clearly.)*	
Name of City elective officer(s): **Members, San Francisco Board of Supervisors**	City elective office(s) held: **Members, San Francisco Board of Supervisors**

Contractor Information *(Please print clearly.)*

Name of contractor: United HealthCare Services, Inc. (for City Plan)

Please list the names of (1) members of the contractor's board of directors; (2) the contractor's chief executive officer, chief financial officer and chief operating officer; (3) any person who has an ownership of 20 percent or more in the contractor; (4) any subcontractor listed in the bid or contract; and (5) any political committee sponsored or controlled by the contractor. Use additional pages as necessary.

1. The United HealthCare Services, Inc. Directors are William Arnold Munsell, and Brian Robert Thompson.

2. The United HealthCare Services, Inc. Officers include:
   CEO and President: William Arnold Munsell
   CFO: Eric Stuart Rangen
   Secretary: Jay Anthony Warmuth
   Treasurer: Robert Worth Oberrender
   Assistant Secretary: Michelle Marie Huntley Dill
   Assistant Secretary: Juanita Boland Luis

3. No person owns 20 percent or more in the contractor.

4. We provide most of our core services directly through the UnitedHealth Group family of companies. This allows us to offer affordable solutions through integrated data elements and systems, streamlined implementations and unified account management support.

   We do work with a variety of external vendors and subcontractors and have listed some of these third parties and the different capacities in which we interact with them. Due to the broad spectrum of UnitedHealth Group businesses and variations in the contractual relationships we have with each vendor or subcontractor, this list is subject to change and should not be considered exhaustive.

   VENDORS AND SUBCONTRACTORS

   NETWORK LEASING

   UnitedHealthcare owns the majority of networks we use for providing health care coverage. However, we use leased or vendor networks where it is not feasible to develop our own network. Vendor networks must comply with the same quality standards we use for our own networks. Vendor network compensation varies based on market demands and the customary practices of the local marketplace. We retain responsibility for claim processing. In addition, we oversee all quality issues, including quality control of the physicians and other health care professionals in the network.

Overpayment Identification Vendors

We contract with a number of vendors to identify overpayments. These vendors perform a variety of audits, including, but not limited to, credit balance, data mining, coordination of benefits (COB), contract audits, DRG audits, workers' compensation and subrogation. Generally, these vendors do not perform collections on the overpayments they identify in an effort to reduce the number of vendors approaching physicians. A collection vendor is assigned to collect these overpayments.

Overpayment Collection Vendors

We contract with a number of vendors to collect overpayments that are identified internally or from an overpayment identification vendor. Overpayment collection vendors are responsible for sending out the initial overpayment notification letter and will follow up with the physician on outstanding balances through phone calls or subsequent recovery letters. These vendors assist with the resolution of physician disputes/appeals.

Maternity Management

We subcontract with Alere (formerly Matria Healthcare) to provide portions of our Healthy Pregnancy Program (HPP). We do use an outside vendor for external review on selected cases.

Shared Savings Program (SSP)

We use Viant, Three Rivers Physician's Network, First Health Networks and MultiPlan's national network of hospitals, physicians and other health care professionals to provide discounts to our customers for non-network claims through our SSP.

Health Information

Various internal and external sources provide health content to our member website, **myuhc.com**. Each resource maintains relationships with various health professionals who write, edit and review the content created for the site. We screen each vendor for accuracy and independence of content.

Surveys

We conduct an annual satisfaction survey based upon the HEDIS 3.0 standards.

Administration of the CAHPS survey is a joint effort between the Survey Research Studies division of OptumInsight (a UnitedHealth Group company) and the Center for the Study of Services (CSS). CSS is certified by NCQA as a CAHPS survey vendor.

Social Security Advocacy Assistance

Social Security advocacy assistance is provided through another vendor. Claim specialists are trained to educate, guide and monitor the application process for Social Security disability benefits. We then consider offering assistance through Social Security Law Group.

ID Cards

Our member medical ID cards are produced by Fiserv Output Solutions, a business unit of Fiserv, Inc. Fiserv, headquartered in Stafford, Texas, is a provider of business-critical communications to the financial services, health care, telecommunications, investment services and retail markets.

Legal

We will be responsible for holding our vendors to the same standards and requirements to which we agree. We will accept responsibility to the extent that our subcontracted vendor fails to meet any contractual obligation assumed by us. 5. In California, corporate contributions are legal, and all of our political giving is through the United HealthCare Services, Inc. corporate entity, which registers as a major donor committee with the state. We are happy to provide additional information at the parent company level (UnitedHealth Group) for states other than California, upon request.
Contractor address: UnitedHealth Group Center 9900 Bren Road East Minnetonka, Minnesota 55343

Date that contract was approved:	Amount of contract: $62,077,000.00 total spend estimated for calendar year 2014*
Describe the nature of the contract that was approved: Self-Insured Medical Plan and Prescription Drug sponsored by CCSF and whose claims administration is outsourced to UnitedHealth Services, Inc., as well as a fully insured PDP Drug Plan for Medicare A and B retirees	
Comments:* The amount of this contract is based on the most recent actuarial information and will change due to actual claims, employee resignations, new hires, terminations and other attrition factors, as well as member selections at the time of qualifying events.	

This contract was approved by (check applicable):

☐ the City elective officer(s) identified on this form

☐ a board on which the City elective officer(s) serves San Francisco Board of Supervisors
Print Name of Board

☐ the board of a state agency (Health Authority, Housing Authority Commission, Industrial Development Authority Board, Parking Authority, Redevelopment Agency Commission, Relocation Appeals Board, Treasure Island Development Authority) on which an appointee of the City elective officer(s) identified on this form sits

_____
Print Name of Board

Filer Information (*Please print clearly.*)	
Name of filer: Angela Calvillo, Clerk of the Board	Contact telephone number: (415) 554-5184
Address: City Hall, Room 244 1 Dr. Carlton B. Goodlett Place, San Francisco, CA 94102	E-mail: Board.of.Supervisors@sfgov.org

_____ _____
Signature of City Elective Officer (if submitted by City elective officer) Date Signed

_____ _____
Signature of Board Secretary or Clerk (if submitted by Board Secretary or Clerk) Date Signed

FILE NO. 130653

FORM SFEC-126:
NOTIFICATION OF CONTRACT APPROVAL
(S.F. Campaign and Governmental Conduct Code § 1.126)

City Elective Officer Information *(Please print clearly.)*	
Name of City elective officer(s): **Members, San Francisco Board of Supervisors**	City elective office(s) held: **Members, San Francisco Board of Supervisors**

Contractor Information *(Please print clearly.)*

Name of contractor:
Delta Dental of California (Delta Dental PPO Active Self Insured and Retiree PPO fully insured, and DeltaCare DHMO)

Please list the names of (1) members of the contractor's board of directors; (2) the contractor's chief executive officer, chief financial officer and chief operating officer; (3) any person who has an ownership of 20 percent or more in the contractor; (4) any subcontractor listed in the bid or contract; and (5) any political committee sponsored or controlled by the contractor. Use additional pages as necessary.

(1)DIRECTORS AND OFFICERS

Barbara J. Burgel
100 First Street
San Francisco, CA 94105

D. Douglas Cassat, DDS
100 First Street
San Francisco, CA 94105

Lynn L. Franzoi
100 First Street
San Francisco, CA 94105

Devang M. Gandhi, DDS, **Secretary**
100 First Street
San Francisco, CA 94105

Roy Gonella
100 First Street
San Francisco, CA 94105

Beverly A. Kodama, DDS
100 First Street
San Francisco, CA 94105

Steven F. McCann, **1st Vice Chair**
100 First Street
San Francisco, CA 94105

Terry A. O'Toole, **Treasurer**
100 First Street
San Francisco, CA 94105

Renuka (Becky) P. Patel, **Chair**
100 First Street
San Francisco, CA 94105

Stephen R. Pickering, DDS
100 First Street
San Francisco, CA 94105
Gary D. Radine (Ex Officio)
100 First Street
San Francisco, CA 94105

Jo Bonita Rains
100 First Street
San Francisco, CA 94105

Andrew J. Reid, **2nd Vice Chair**
100 First Street
San Francisco, CA 94105

Coragene I. Savio, DDS
100 First Street
San Francisco, CA 94105

Steven W. Voss
100 First Street
San Francisco, CA 94105

Thomas A. Zimmerman
100 First Street
San Francisco, CA 94105

(2)
Chief Executive Officer – Gary Radine
Chief Financial Officer – Michael Castro
Chief Operating Officer – Tony Barth

(3)
None

(4)
None

(5)
None

Contractor address:
100 First Street, San Francisco, California 94105

Date that contract was approved:	Amount of contract estimated for CY 2014: **$57,266,493.00*** Delta Dental PPO - **Policy Number 1673 – Retirees** $11,215,907.00 Delta Dental PPO - **Policy 9502 – Actives: (Self-funded Claims + Admin.)** $45,032,742.00 DeltaCare USA – DHMO **Policy # 01797 – DeltaCare:** $1,017,844.00
Describe the nature of the contract that was approved: Dental Benefits	
Comments: *The amount of this contract is based on the most recent information and will change due to employee resignations, new hires, terminations and other attrition factors, as well as member selections at the time of qualifying events. The Delta Dental PPO Active Self-Insured Plan is based on actual claims and administration.	

This contract was approved by (check applicable):

☐ the City elective officer(s) identified on this form

☐ a board on which the City elective officer(s) serves San Francisco Board of Supervisors
Print Name of Board

☐ the board of a state agency (Health Authority, Housing Authority Commission, Industrial Development Authority Board, Parking Authority, Redevelopment Agency Commission, Relocation Appeals Board, Treasure Island Development Authority) on which an appointee of the City elective officer(s) identified on this form sits

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FILE NO. 130653

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City Elective Officer Information *(Please print clearly.)*	
Name of City elective officer(s): **Members, San Francisco Board of Supervisors**	City elective office(s) held: **Members, San Francisco Board of Supervisors**

Contractor Information *(Please print clearly.)*

Name of contractor: DENTAL BENEFIT PROVIDERS OF CALIFORNIA, INC., a subsidiary of United HealthGroup [***Pacific Union***]

Please list the names of (1) members of the contractor's board of directors; (2) the contractor's chief executive officer, chief financial officer and chief operating officer; (3) any person who has an ownership of 20 percent or more in the contractor; (4) any subcontractor listed in the bid or contract; and (5) any political committee sponsored or controlled by the contractor. Use additional pages as necessary.

The United HealthCare Services, Inc. Directors are William Arnold Munsell, and Brian Robert Thompson.

2. The United HealthCare Services, Inc. Officers include:
CEO and President: William Arnold Munsell
CFO: Eric Stuart Rangen
Secretary: Jay Anthony Warmuth
Treasurer: Robert Worth Oberrender
Assistant Secretary: Michelle Marie Huntley Dill
Assistant Secretary: Juanita Boland Luis

3. No person owns 20 percent or more in the contractor.

6. We provide most of our core services directly through the UnitedHealth Group family of companies. This allows us to offer affordable solutions through integrated data elements and systems, streamlined implementations and unified account management support.

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VENDORS AND SUBCONTRACTORS

NETWORK LEASING

UnitedHealthcare owns the majority of networks we use for providing health care coverage. However, we use leased or vendor networks where it is not feasible to develop our own network. Vendor networks must comply with the same quality standards we use for our own networks. Vendor network compensation varies based on market demands and the customary practices of the local marketplace. We retain responsibility for claim processing. In addition, we oversee all quality issues, including quality control of the physicians and other health care professionals in the network.

Overpayment Identification Vendors

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Maternity Management

We subcontract with Alere (formerly Matria Healthcare) to provide portions of our Healthy Pregnancy Program (HPP). We do use an outside vendor for external review on selected cases.

Shared Savings Program (SSP)

We use Viant, Three Rivers Physician's Network, First Health Networks and MultiPlan's national network of hospitals, physicians and other health care professionals to provide discounts to our customers for non-network claims through our SSP.

Health Information

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We conduct an annual satisfaction survey based upon the HEDIS 3.0 standards.

Administration of the CAHPS survey is a joint effort between the Survey Research Studies division of OptumInsight (a UnitedHealth Group company) and the Center for the Study of Services (CSS). CSS is certified by NCQA as a CAHPS survey vendor.

Social Security Advocacy Assistance

Social Security advocacy assistance is provided through another vendor. Claim specialists are trained to educate, guide and monitor the application process for Social Security disability benefits. We then consider offering assistance through Social Security Law Group.

ID Cards

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Legal

We will be responsible for holding our vendors to the same standards and requirements to which we agree. We will accept responsibility to the extent that our subcontracted vendor fails to meet any

contractual obligation assumed by us.

7. In California, corporate contributions are legal, and all of our political giving is through the United HealthCare Services, Inc. corporate entity, which registers as a major donor committee with the state. We are happy to provide additional information at the parent company level (UnitedHealth Group) for states other than California, upon request.

Contractor address:
UnitedHealth Group Center
9900 Bren Road East
Minnetonka, Minnesota 55343

Date that contract was approved:	Amount of contract estimated: **$326,188 (calendar year 2014)***

Describe the nature of the contract that was approved:
DMO Dental Coverage for both active and retirees

Comments:
*The amount of this contract is based on the most recent information and will change due to employee resignations, new hires, terminations and other attrition factors, as well as member selections at the time of qualifying events.

This contract was approved by (check applicable):

☐ the City elective officer(s) identified on this form

☐ a board on which the City elective officer(s) serves San Francisco Board of Supervisors
Print Name of Board

☐ the board of a state agency (Health Authority, Housing Authority Commission, Industrial Development Authority Board, Parking Authority, Redevelopment Agency Commission, Relocation Appeals Board, Treasure Island Development Authority) on which an appointee of the City elective officer(s) identified on this form sits

Print Name of Board

Filer Information *(Please print clearly.)*	
Name of filer: Angela Calvillo, Clerk of the Board	Contact telephone number: (415) 554-5184
Address: City Hall, Room 244 1 Dr. Carlton B. Goodlett Place, San Francisco, CA 94102	E-mail: Board.of.Supervisors@sfgov.org

Signature of City Elective Officer (if submitted by City elective officer) Date Signed

Signature of Board Secretary or Clerk (if submitted by Board Secretary or Clerk) Date Signed

FILE NO. 130653

FORM SFEC-126:
NOTIFICATION OF CONTRACT APPROVAL

(S.F. Campaign and Governmental Conduct Code § 1.126)

City Elective Officer Information *(Please print clearly.)*	
Name of City elective officer(s): **Members, San Francisco Board of Supervisors**	City elective office(s) held: **Members, San Francisco Board of Supervisors**

Contractor Information *(Please print clearly.)*	
Name of contractor: Vision Service Plan (VSP)	
Please list the names of (1) members of the contractor's board of directors; (2) the contractor's chief executive officer, chief financial officer and chief operating officer; (3) any person who has an ownership of 20 percent or more in the contractor; (4) any subcontractor listed in the bid or contract; and (5) any political committee sponsored or controlled by the contractor. Use additional pages as necessary. *1)Tim Jankowski O.D, Stuart Thomas O.D, Ron Reynolds O.D., Jim Winnick O.D., Gary Sheppard, Dan Mannen O.D., Mark Bronstein M.D., Walter Grubbs, Gordon Jennings O.D., Ken Johnson O.D., Randy Lee O.D., Leslie Murphy CPA, Matthew Alpert O.D.* *2)Rob Lynch, CEO, Jim McGrann, VSP Vision Care President, Don Ball, CFO, Laura Costa, COO* *3)not applicable, as VSP is a non profit institution* *4)not applicable* *5)not applicable*	
Contractor address: 3333 Quality Drive, Rancho Cordova, CA 95670	
Date that contract was approved:	Amount of contract: (estimated) **$4,595,580.00 (calendar year 2014)***
Describe the nature of the contract that was approved: **Vision benefit**	
Comments: *The amount of this contract is based on the most recent information and will change due to employee resignations, new hires, terminations and other attrition factors, as well as member selections at the time of qualifying events.	

This contract was approved by (check applicable):

☐ the City elective officer(s) identified on this form

☐ a board on which the City elective officer(s) serves San Francisco Board of Supervisors
Print Name of Board

☐ the board of a state agency (Health Authority, Housing Authority Commission, Industrial Development Authority Board, Parking Authority, Redevelopment Agency Commission, Relocation Appeals Board, Treasure Island Development Authority) on which an appointee of the City elective officer(s) identified on this form sits

Print Name of Board

Filer Information (*Please print clearly.*)	
Name of filer: Angela Calvillo, Clerk of the Board	Contact telephone number: (415) 554-5184
Address: City Hall, Room 244 1 Dr. Carlton B. Goodlett Place, San Francisco, CA 94102	E-mail: Board.of.Supervisors@sfgov.org

Signature of City Elective Officer (if submitted by City elective officer) — Date Signed

Signature of Board Secretary or Clerk (if submitted by Board Secretary or Clerk) — Date Signed

FORM SFEC-126:
NOTIFICATION OF CONTRACT APPROVAL
(S.F. Campaign and Governmental Conduct Code § 1.126)

City Elective Officer Information (*Please print clearly.*)	
Name of City elective officer(s): **Members, San Francisco Board of Supervisors**	City elective office(s) held: **Members, San Francisco Board of Supervisors**

Contractor Information (*Please print clearly.*)

Name of contractor:
Aetna Life Insurance Company

Please list the names of (1) members of the contractor's board of directors; (2) the contractor's chief executive officer, chief financial officer and chief operating officer; (3) any person who has an ownership of 20 percent or more in the contractor; (4) any subcontractor listed in the bid or contract; and (5) any political committee sponsored or controlled by the contractor. Use additional pages as necessary.

(1) Contractor (Aetna) Board of Directors

- *Fernando Aguirre, Former Chairman, President and Chief Executive Officer Chiquita Brands International, Inc.*
- *Mark T. Bertolini Chairman, Chief Executive Officer and President Aetna*
- *Frank M. Clark, Former Chairman and Chief Executive Officer Commonwealth Edison Company*
- *Betsy Z. Cohen, Chief Executive Officer The Bancorp, Inc*
- *Molly J. Coye, M.D., Chief Innovation Officer UCLA Health System*
- *Roger N. Farah, President, Chief Operating Officer and Director Ralph Lauren Corporation*
- *Barbara Hackman Franklin, President and Chief Executive Officer Barbara Franklin Enterprises, Former U.S. Secretary of Commerce*
- *Jeffrey E. Garten, Juan Trippe Professor in the Practice of International Trade, Finance and Business, Yale University*
- *Ellen M. Hancock, Former President of Jazz Technologies, Inc., Former Chairman and Chief Executive Officer of Exodus Communications, Inc.*
- *Richard J. Harrington, Chairman The Cue Ball Group, Former President and Chief Executive Officer The Thomson Corporation*
- *Edward J. Ludwig, Former Chairman and Chief Executive Officer Becton, Dickinson and Company*
- *Joseph P. Newhouse, John D. MacArthur Professor of Health Policy and Management Harvard University*

(2) Contractor (Aetna) Chief Executive Officer/Chief Financial Officer/Chief Operating Officer

- *Mark T. Bertolini Chairman, Chief Executive Officer and President Aetna*
- *Shawn Guertin, Senior Executive Vice President, Chief Financial Officer*
- *Meg McCarthy is Executive Vice President, Operations & Technology.*

(3) Any person who has an ownership of 20% or more

- *Aetna is a publically traded company with no one person or entity having 20% or more ownership*

(4) Any subcontractor listed in the bid.

- *Affiliated Customer Services*
- *Allsup*
- *Computer Sciences Corporation*
- *Coventry Priority Services*
- *IBM Daksh*
- *International Beneficiary Locators, Inc.*
- *Intracorp*
- *Open Solutions and Harland (formerly BISYS)*
- *Perot*
- *The Rawlings Company*

(5) Any Political committee sponsored or controlled by the contractor

- *Aetna Political Action Committee (PAC)*
  - *i. Aetna PAC is a bipartisan political action committee, an organization that enables company employees to have a voice with legislators who make laws and policy that have a direct impact on the way the*

company does business. Its purpose is to collect voluntary contributions from eligible Aetna employees and then use these funds to support candidates for federal and state political office in accordance with applicable election laws.	
Contractor address: 151 Farmington Avenue Hartford, CT 06156	
Date that contract was approved:	Amount of contract: (estimated for CY 2014) Life (basic and supplemental): $392,988 Long Term Disability(LTD): $5,687,262 TOTAL: $6,080,250
Describe the nature of the contract that was approved: **1.) Basic Group Life and Supplemental Life, and;** **2.) Long Term Disability Insurance**	
Comments: *The amount of this contract is based on the most recent information and will change due to employee resignations, new hires, terminations and other attrition factors, as well as member selections at the time of qualifying events.	

This contract was approved by (check applicable):

☐ the City elective officer(s) identified on this form

☐ a board on which the City elective officer(s) serves San Francisco Board of Supervisors
Print Name of Board

☐ the board of a state agency (Health Authority, Housing Authority Commission, Industrial Development Authority Board, Parking Authority, Redevelopment Agency Commission, Relocation Appeals Board, Treasure Island Development Authority) on which an appointee of the City elective officer(s) identified on this form sits

Print Name of Board

Filer Information *(Please print clearly.)*	
Name of filer: Angela Calvillo, Clerk of the Board	Contact telephone number: (415) 554-5184
Address: City Hall, Room 244 1 Dr. Carlton B. Goodlett Place, San Francisco, CA 94102	E-mail: Board.of.Supervisors@sfgov.org

Signature of City Elective Officer (if submitted by City elective officer) — Date Signed

Signature of Board Secretary or Clerk (if submitted by Board Secretary or Clerk) — Date Signed