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June 18, 2025

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, 2026 to December 31, 2026 Health, Life Insurance, and Long-Term Disability Plan Benefits, Rates and Contributions

Honorable Members of the Board of Supervisors:

This letter serves to document our position as the consultant and actuary to the San Francisco Health Service System ("SFHSS") with regard to the completed rates and contribution setting process for SFHSS medical/prescription drug, dental, vision, life insurance, and long-term disability plans for the January 1, 2026, to December 31, 2026, plan year. Four employers (referred to as the "Four Employers" in this letter) offer plans through SFHSS, which are documented in this letter, to active employees and retirees:

- City and County of San Francisco, or CCSF (all plans documented in this letter);
- San Francisco Unified School District, or USD (medical and vision plans only);
- City College of San Francisco, or CCD (medical and vision plans only); and
- The Superior Court of San Francisco, or CRT (all plans documented in this letter).

The 2026 plan year rates and contribution setting process was concluded on June 12, 2025, under the direction of the Rates and Benefits Committee ("Committee") of the Health Service Board ("HSB"). This report will reference attached exhibits, as well as tables embedded in this letter.

In our opinion, the rate and contribution determination process for the 2026 plan year was completed in a comprehensive manner. Specifically, it is our professional opinion that:

- The premium rates for all fully insured plans, and the administrative/other fees for all self-funded and flex-funded plans, align with SFHSS' vendors' final rates and represent a fair price for the services provided.
- The premium equivalents set for the SFHSS self-funded and flex-funded programs listed below represent our best estimate of future expenditures based on the information available at the time these rates were developed. Existing Trust Fund assets are expected to be sufficient to protect the SFHSS Trust Fund against adverse claims experience. The self-funded and flex-funded programs include:
  - Blue Shield of California ("BSC") self-funded PPO and flex-funded Access+/Trio HMO plans, including non-Medicare family members where at least one family member is enrolled in the Medicare Advantage PPO plan (e.g., "split family retirees");
  - Health Net CanopyCare ("HN CC") flex-funded HMO plan; and
  - Delta Dental of California ("Delta Dental") self-funded PPO plan for active employees.

Legislative Update

California: Senate Bill 729
On September 29, 2024 Governor Newsom signed SB729 which orders group health care plans and disability insurance policies issued, amended, or renewed on or after July 1, 2025, to cover the diagnosis and treatment of infertility and fertility services. This bill aims to enhance access to fertility services by including coverage for up to three completed oocyte retrievals and revising the definition of infertility, removing the in vitro fertilization exclusion. Additionally, the bill prohibits health care plans and insurers from imposing different conditions on fertility treatments compared to other medical conditions, with exceptions for religious employers and certain specified contracts.

Federal: The Consolidated Appropriations Act (CAA)

The Consolidated Appropriations Act, 2021 (CAA) established protections for consumers related to surprise billing and transparency in health care. Under the guidance of the City Attorney's office, SFHSS has worked diligently with its vendor partners to ensure compliance with the CAA. This includes the following:

- Prescription drug and health care spending data submission: Completion of the initial pharmacy transparency data required under section 204 of Title II (Transparency) of Division BB of the CAA which requires insurance companies and employer-based health plans to submit information about prescription drug and health care spending to the Departments of Health & Human Services, Labor, and Treasury.
- No Surprises Act: Confirming vendor implementation of Title I (the No Surprises Act (NSA)) of Division BB of the Consolidated Appropriations Act, 2021 (CAA 2021) and regulations published in the Federal Register on July 13, 2021, and October 7, 2021.
- Gag Clause Prohibition: Confirming vendors and SFHSS have completed the most recent annual Gag Clause Prohibition Compliance Attestation (GCPCA) as required under section 201 of Title II (Transparency) of Division BB of the CAA. The law requires certain plans and issuers to submit an attestation of compliance to the Departments of Health & Human Services, Labor, and the Treasury on an annual basis.

Federal: Transparency in Coverage Final Rule

As of July 1, 2022, most group health plans and issuers of group health insurance coverage are required to disclose, on a public website, machine-readable files (MRFs) containing in-network rates for covered items and services and allowed amounts and historical billed charges for out-of-network providers. SFHSS worked with its vendors to comply with this final rule by gathering the needed MRF reference links from each vendor and posting them on the SFHSS website.

Federal: Funding Impacts to Medicare Advantage Plan Costs

Two developments at the federal level have led to higher-than-typical Medicare Advantage Prescription Drug (MAPD) Plan rate increases into 2025 and 2026, relative to prior years—the Inflation Reduction Act (passed into law in August 2022) and reduced growth in government funding of Medicare Advantage plans by the entity that oversees Medicare, the Centers for Medicare and Medicaid (CMS).

The Inflation Reduction Act improved the standard Medicare Part D prescription drug plan benefit by implementing a $2,000 overall member out-of-pocket maximum in 2025. As a result, though this does not impact plan designs for the MAPD plans offered by SFHSS (Blue Shield of California MAPD PPO and Kaiser MAPD HMO), MAPD carriers have been incorporating the higher cost anticipated for their plans into plan rating. Coupled with reductions in funding growth rates into MAPD plans by CMS—where the federal government funds much of the total plan cost for MAPD plans—this has led to higher MAPD rate increases in the market. Plan year 2026 is the third year of a three-year adjustment period for CMS federal funding growth rates for MAPD plans. The carrier change from UnitedHealthcare (UHC) to BSC for the 2025 plan year mitigated the financial impacts described above to SFHSS into 2025, 2026, and 2027.

Federal: The Patient Protection and Affordable Care Act (PPACA)

PPACA continues as law, and thus SFHSS continues to work with the Four Employers served by the Trust to assure compliance with PPACA requirements continues. Below is a brief explanation of the provisions that remain in place currently and have the greatest effect.

PPACA Reporting Requirements

Under PPACA, employers are required to provide reporting to both employees as well as the Internal Revenue Service (IRS). This reporting requirement remains even though the individual mandate penalty moved to $0 for the 2019 plan year and forward. The purpose of the reporting is as follows:

- Establish that the plan sponsor complied with PPACA's employer mandate by making an offer of affordable, minimum-value health care coverage to its full-time employees (PPACA defines a full-time employee as an employee who is employed, on average, at least 30 hours of service per week, or 130 hours of service in a calendar month);

- Provide individuals with information on their employer-provided health care coverage so they can establish compliance with the individual mandate to purchase health care coverage;
- Help the IRS determine whether individuals who have purchased coverage from a public exchange are entitled to a subsidy; and
- Help the IRS determine applicable penalties for failure to comply with the individual mandate.

Reporting started in 2016 with 2015 calendar year information on Forms 1094 and 1095 and remains an annual requirement. SFHSS successfully met this requirement for the 2024 plan year by creating 51,491 IRS forms for distribution to employees and electronic reporting to the IRS in early 2025.

PPACA Legislative Fees

The one ongoing Patient Protection and Affordable Care Act (PPACA) fee which employers are responsible for paying is the Patient Centered Outcomes Research Institute (PCORI) Fee. PCORI remains in effect through 2029 as part of the SECURE Act passed by the federal government in December 2019. The fee is included in fully insured plan premiums, while SFHSS is responsible for payment for self-funded medical plans. The 2026 PCORI fee is expected to be slightly higher than the $3.47 per covered life per year fee in 2025.

Contributions Under the 10-County Survey

Per City Charter Section A8.428, the employer contribution towards medical benefits is determined by the results of a survey of the dollar premium contributions provided by the ten most populous counties in California, excluding San Francisco. In the June 2014 CCSF collective bargaining process, the 10-County Survey ("Survey") was eliminated for the majority of the CCSF unions in the calculation of premium contributions for active employees in exchange for a percentage-based employee premium contribution. The Survey is the basis for calculating employer contributions for retirees and some employees in SFHSS health plans. For 2026 rating, the 10-County Survey result leads to an increase in average monthly employer contribution from $882.05 in 2025 to $942.14 in 2026 (an increase of 6.81%). The full Survey report is contained as an Appendix to this letter and was presented at the March 13, 2025, HSB meeting (also accessible at sfhss.org). Survey results are illustrated in Exhibit 1 of the adjoining document.

Projected 2026 Aggregate Medical Plans Cost

Per Table 1 below, we expect an increase in aggregate medical plan costs totaling $99.3 million, or 8.33%, for the SFHSS medical plans (including Basic Plan vision coverage costs which are unchanged from 2025, and the SFHSS Healthcare Sustainability Fund charge which is increasing by $2 per member per month to $6 per member per month in 2026) for the 2026 plan year. This increase in costs will be split between the members and employers with member contributions increasing $10.2 million and employer contributions increasing $89.1 million. These costs are projected based on February 2025 plan enrollment.

Table 1 — All Four Employers January 1, 2026 to December 31, 2026 Aggregate Medical Plans Cost ($ millions)			
	Aggregate Member Contributions (a)	Aggregate Employer Contributions (b)	Aggregate Plan Cost (a + b)
Current (2025) Rates	**$140.8**	**$1,050.6**	**$1,191.4**
Final Renewal (2026) Rates	**$151.0**	**$1,139.7**	**$1,290.7**
$ Difference	$10.2	$89.1	$99.3
% Difference	7.24%	8.48%	8.33%
2026 Rate Sharing Distribution	11.7%	88.3%	100.0%

Current CCSF Health Plan Employer Contribution Strategy — Active Employees

Most negotiated contribution algorithms for CCSF covered employees fall into two models. The models reflect CCSF's percentage of the contribution; they are **(1) 93/93/83** contribution model, and **(2) 100/96/83** contribution model.

1) 93/93/83 Contribution Model:

a) Employee Only. For single-covered employees (Employee Only) who enroll in any health plan offered through the San Francisco Health Service System (SFHSS), CCSF shall contribute ninety-three percent (93%) of the total health insurance premium/premium equivalent provided. However, CCSF's contribution shall be capped at ninety-three percent (93%) of the Employee Only premium/premium equivalent of the second highest-cost plan.

b) Employee Plus One. For employees with one dependent who elect to enroll in any health plan offered through SFHSS, CCSF shall contribute ninety-three percent (93%) of the total health insurance premium/premium equivalent provided. However, CCSF's contribution shall be capped at ninety-three percent (93%) of the Employee Plus One premium/premium equivalent of the second highest-cost plan.

c) Employee Plus Two or More. For employees with two or more dependents who elect to enroll in any health plan offered through SFHSS, CCSF shall contribute eighty-three (83%) of the total health insurance premium/premium equivalent provided. However, CCSF's contribution shall be capped at eighty-three percent (83%) of the Employee Plus Two or More premium/premium equivalent of the second highest-cost plan.

2) **100/96/83 Contribution Model:**

a) **Employee Only.** For single-covered employees (Employee Only) who enroll in any health plan offered through SFHSS, CCSF shall contribute one hundred percent (100%) of the total health insurance premium/premium equivalent.

b) **Employee Plus One.** For employees with one dependent who elect to enroll in any health plan offered through SFHSS, CCSF shall contribute ninety-six percent (96%) of the total health insurance premium/premium equivalent provided. However, CCSF's contribution shall be capped at ninety-six percent (96%) of the Employee Plus One premium/premium equivalent of the second highest-cost plan.

c) **Employee Plus Two or More.** For employees with two or more dependents who elect to enroll in any health plan offered through SFHSS, CCSF shall contribute eighty-three (83%) of the total health insurance premium/premium equivalent provided. However, CCSF's contribution shall be capped at eighty-three percent (83%) of the Employee Plus Two or More premium/premium equivalent of the second highest-cost plan.

Since the majority of CCSF employees fall into the two contribution models, Aon produced two sets of rate cards, both approved by the HSB for plan year 2026. One rate card specified member contributions under the 93/93/83 model and the other rate card under the 100/96/83 model.

Current CCSF Health Plan Employer Contribution Strategy — Retirees

For SFHSS retirees, the employer contributions that member employers including CCSF provide to qualified retirees receiving the full employer contribution amounts are defined by Section A8.428 of the City Charter. The three elements are:

- **10-County Survey Amount.** This first component of the employer contribution is the amount derived from the annual survey described in Charter Section A8.423 of contributions provided by the 10 most populous counties in California, not including San Francisco — called the "average contribution". The 2026 10-County amount is $942.14. If the total cost for Retiree Only for a plan is less than the 10-County Amount, that lower amount becomes the basis for that plan for the 10-County employer contribution portion.
- **"Actuarial Difference".** The second employer contribution component is the "actuarial difference" for a given plan. Under Charter Section A8.428(b)(3), the employers contribute the difference between Active Employee-Only premium and non-Medicare Retiree-Only premium.
- **Prop. E Contribution.** The third employer contribution component is the Prop. E contribution amount. Under Charter Section A8.428(b)(3)(iii) and A8.428(c), employer contributions toward Retiree Only and Retiree +1 rates = 50% x [Total Rate Cost – 10-County Amount – "Actuarial Difference"].

The full employer contribution amount for retiree medical coverage applies to eligible retirees who were hired on or before January 9, 2009. For retirees who were hired on or after January 10, 2009, there are five coverage/employer contribution classifications based on criteria outlined in Table 2 below.

Table 2 — Retiree Medical Coverage/Employer Contribution For Those Hired On or After January 10, 2009

Years of Credited Service at Retirement	Percentage of Employer Contribution Established in A8.428 Subsection (b)(3)
Less than 5 years of Credited Service with the Employers (except for the surviving spouses or surviving domestic partners of active employees who died in the line of duty)	No Retiree Medical Benefits Coverage

Table 2 — Retiree Medical Coverage/Employer Contribution For Those Hired On or After January 10, 2009	
Years of Credited Service at Retirement	**Percentage of Employer Contribution Established in A8.428 Subsection (b)(3)**
At least 5 but less than 10 years of Credited Service with the Employers; or greater than 10 years of Credited Service with the Employers but not eligible to receive benefits under Subsections (a)(4), (b)(4) and (b)(5) **(A8.428 Subsection (b)(6))**	0% — Access to Retiree Medical Benefits Coverage, Including Access to Dependent Coverage, But No Employer Contribution; Employee Pays Health Insurance Premium
At least 10 but less than 15 years of Credited Service with the Employers **(A8.428 Subsection (b)(5))**	50%
At least 15 but less than 20 years of Credited Service with the Employers **(A8.428 Subsection (b)(5))**	75%
At least 20 years of Credited Service with the Employers; Retired Persons who retired for disability; surviving spouses or surviving domestic partners of active employees who died in the line of duty **(A8.428 Subsection (b)(4))**	100%

Outline of 2026 Health Plan Design and Rating Actions

Below we describe the plan design changes and rating actions that apply to each SFHSS health plan for the 2026 plan year, based on approval actions taken during the recently completed Rates and Benefits cycle by the HSB.

Rates, Contributions, and Benefits for the Fully Insured Kaiser Permanente HMO Plans for All Four Employers

The final negotiated rate change for Kaiser Permanente ("Kaiser") Non-Medicare plan—which include "split family" covered lives—and Kaiser Medicare retirees is an overall increase of 9.82% for plan year 2026. This overall average is generated by a 9.88% premium rate increase for the non-Medicare plan in California, and an 9.33% premium rate increase for Medicare retirees in California. There are also small retiree populations (226 covered lives) with Kaiser HMO coverage in the Northwest (Oregon), Washington, and Hawaii regions with an overall increase for these "multi-region" retiree Kaiser HMO plans outside of California of 3.5%.

The Kaiser California non-Medicare plan reflects the adoption of SB729 infertility benefit level requirements placed on fully insured commercial plans in California effective in 2026. There are no other 2026 plan design changes approved for the Kaiser plans.

The 2026 Kaiser California HMO renewal actions result in an overall estimated total cost increase of $58.1 million from 2025 to 2026 for all four employers based on February 2025 membership, of which $46.8 million is attributed to CCSF and $11.3 million is attributed to the other employer groups (e.g., CRT, USD, and CCD).

The aggregate 2026 projected cost for all four employers for Kaiser Permanente in California based on February 2025 membership is projected at $645.6 million, with $68.4 million in member contributions and $577.2 million in employer contributions. Table 3 (page 12) provides an overview of annualized costs.

The 2026 Kaiser plan rates are illustrated in exhibits 2a-2e in the adjoining document.

Rates, Contributions, and Benefits for the Fully Insured BSC MAPD PPO Plan, Flex-Funded BSC HMO Plans, and Self-Funded BSC PPO Plan for All Four Employers

For BSC Non-Medicare plans—which include “split family” covered lives—total cost rates will increase by 8.7% for the BSC Access+ HMO plan, 9.2% for the BSC Trio HMO plan, and 0.5% for the PPO plan into the 2026 plan year. Overall, this produces an aggregate total rate increase of 7.6% for the combination of Non-Medicare BSC HMO and PPO plans into the 2026 plan year.

For BSC Medicare plans, total cost rates will increase by 4.5%. This is driven by the three-year premium guarantee as a result of the Spring of 2024 RFP process for the Medicare Advantage Prescription Drug (MAPD) PPO plan and non-Medicare “split family” plans available to non-Medicare covered lives within families where one or more life is Medicare and covered in the MAPD PPO plan. The RFP delivered a projected savings of $67M over the three-year period 2025 through 2027.

The non-Medicare plans reflect the adoption of SB729 infertility benefit level requirements placed on fully insured commercial plans in California effective in 2026. The Rates and Benefits Committee and HSB also approved the application of SB729 to the self-funded, non-Medicare PPO plan. The Rates and Benefits Committee and HSB approved one plan change that applies to all three non-Medicare plans (BSC Access+ HMO, BSC Trio HMO, and BSC PPO). The change, which aligns the BSC plans with the Kaiser HMO approach to glucagon-like peptide-1’s (GLP-1’s) effective for the 2025 plan year, restricts coverage for GLP-1 medications for weight loss only (e.g., no approved qualifying diagnosis) for individuals with Body Mass Index (BMI) at or above 40 (e.g., Class III Obesity). These changes are reflected in the rate information shown above and in attached Exhibits.

The aggregate 2026 projected cost for all four employers in the BSC MAPD PPO, BSC Access+, BSC Trio, and BSC Non-Medicare PPO plans based on February 2025 BSC plan enrollments is $630.6 million, with $81.2 million in member contributions and $549.4 million in employer contributions based on February 2025 membership. This results in an overall estimated total cost increase of $41.1 million from 2025 to 2026 for all four employers based on February 2025 membership, of which $36.7 million is attributed to CCSF and the remaining $4.4 million is attributed to the other employer groups (e.g., CRT, USD, and CCD). Table 3 (page 12) provides an overview of annualized costs for the Blue Shield HMO and PPO plans combined.

The 2026 BSC flex-funded HMO plan rates are illustrated in exhibits 3a-3b for the Access+ plan and 3c-3d for the Trio plan in the adjoining document. The 2026 BSC Non-Medicare PPO plan rates are illustrated in exhibits 5a-5d in the adjoining document.

Rates, Contributions, and Benefits for the Flex-Funded Health Net CanopyCare HMO Plan for All Four Employers

The Health Net CanopyCare HMO plan total cost rates will decrease by 0.3% into the 2026 plan year. Health Net CanopyCare was introduced as a new health plan option to SFHSS members for the 2022 plan year. Thus, the 2026 plan year will be the fifth year for the Health Net CanopyCare plan option.

The rates reflect the adoption of SB729 infertility benefit level requirements placed on fully insured plans in California effective in 2026. There are no other 2026 plan design changes approved for the Health Net CanopyCare plan.

Based on the February 2025 membership, the aggregate 2026 projected cost for all four employers in the Health Net CanopyCare HMO Plan for the 2026 plan year is $14.5 million, with $1.4 million in member contributions and $13.1 million in employer contributions. Costs overall are projected to only very slightly decrease from 2025 budget to 2026 budget for this plan given the slight rate decrease of 0.3%.

The 2026 Health Net CanopyCare (flex-funded) HMO plan rates are illustrated in exhibits 4a-4b in the adjoining document.

Rates and Benefits for the Fully Insured Vision Plans for All Four Employers

Members enrolled in any medical plan offered by SFHSS also receive the Basic Plan vision benefits through Vision Service Plan (VSP). The cost of the Basic Plan vision benefit is a component of the cost of the medical plan and

has been included in the rate exhibits referenced above. For the 2026 plan year, Basic Plan rates are remaining at 2025 levels.

There is also a buy-up Premier Plan available to SFHSS members. Members pay the full rate increment between Basic Plan rates and Premier Plan rates. For the 2026 plan year, Premier Plan total premium rates will remain the same as 2025 levels.

Certain employees also have an employer-paid Computer Vision Care benefit, priced at $1.04 per employee per month for 2026. Approximately 21,000 employees have access to this benefit.

There are no 2026 plan design changes approved for the Basic, Premier or Computer Vision Care plans by the Rates and Benefits Committee and HSB.

Based on February 2025 enrollment, the aggregate projected 2026 employer cost for all four employers for the VSP Basic vision plan is $5.64 million (88% of total Basic plan rates based on contribution sharing formulas), plus an additional $0.26 million for the Computer Vision Care benefit. The employer portion of vision plan costs is remaining the same from 2025 to 2026. VSP vision plan costs for all four employers are illustrated in Exhibits 6a-6b in the adjoining document.

Rates, Contributions, and Benefits for Dental Plans for CCSF, Court Employees, and All Retirees

Three dental plans are offered to CCSF/Court active employees and all SFHSS retirees — Delta Dental PPO, DeltaCare USA HMO, and UHC Dental HMO. The Delta Dental PPO plan has a network of preferred providers while the other two plans are dental HMOs with closed panels of providers. Information on proposed 2026 renewal actions follows.

Delta Dental Active Employee PPO Plan (Self-Funded)
The Delta Dental PPO plan for active employees is self-funded and administered by Delta Dental of California (Delta Dental). Future plan costs are projected based on the City employees' claim experience. Delta Dental's administrative fee will remain the same as the 2025 cost at $4.82 per employee per month. Monthly employee contributions for CCSF employees in the Delta Dental PPO plan are $5.00 for the Employee Only tier, $10.00 for the Employee +1 tier, and $15.00 for the Employee +2+ tier.

The aggregate total premium equivalent rates for the self-funded active employee Delta Dental PPO plan for active employees are increasing 12.4% for plan year 2026—an increase of $5.2 million from 2025 active employee Delta Dental PPO plan rates for CCSF. This increase is driven mostly by a reduced level of rate stabilization buy-down funds in the active employee dental PPO plan from the prior year.

The Rates and Benefits Committee and HSB approved one plan enhancement for the Delta Dental Active Employee PPO plan. The change raises the age for children to receive coverage for first molar sealants to age 16 (to age 9 currently). This change is reflected in the rate information shown above and in attached Exhibits.

Dental Active Employee HMO Plans (Fully Insured)
Rates for both active employee HMO plans—DeltaCare USA and UnitedHealthcare—are remaining at respective 2025 rate levels into the 2026 plan year. There are no plan changes approved in these dental HMO plans by the Rates and Benefits Committee and HSB. The active employee dental HMOs are fully paid by the employers with no employee contributions.

Delta Dental Retiree PPO Plan (Fully Insured)
The Delta Dental PPO plan for retirees is fully insured with premiums fully paid by retirees with no employer contributions. The Delta Dental Retiree PPO rate increase from 2025 to 2026 is 2.0% based on a three-year premium guarantee, of which 2026 is the final year. There are no 2026 plan design changes approved for the Delta Dental Retiree PPO plan by the Rates and Benefits Committee and HSB.

Dental Retiree Employee HMO Plans (Fully Insured)
Rates for both retiree employee HMO plans—DeltaCare USA and UnitedHealthcare—are remaining at respective 2025 rate levels into the 2026 plan year. There are no approved plan changes in these dental HMO plans by the Rates and Benefits Committee and HSB. The retiree dental HMOs are fully paid by retirees with no employer contributions.

Dental Rates Summary
The 2026 dental plan rates are shown in the adjoining document for the Delta Dental PPO (Exhibits 7a-7b), DeltaCare USA HMO (Exhibits 8a-8b), and UHC Dental HMO (Exhibits 9a-9b) plans.

The aggregate dental plan total cost for active employees for the 2026 plan year is projected at $48.8 million with $3.8 million in member contributions and $45.0 million in employer contributions based on March 2025 enrollment. This results in an overall estimated total dental cost increase of $5.3 million (12.2%) from 2025 to 2026. Table 3 (page 11) provides an overview of annualized costs.

Life, Accidental Death and Dismemberment (AD&D), Short-Term Disability (STD), and Long-Term Disability (LTD) Insurance for Active and Eligible Employees of the City and County of San Francisco and Superior Court of San Francisco

Following a competitive public Request for Proposal (RFP) issued December 3, 2024 by the San Francisco Health Service System (SFHSS), the Health Service Board (HSB) approved a change in the Life (Group Life and Supplemental Life), Accidental Death & Dismemberment (AD&D), Short-Term Disability, and Long-Term Disability Insurance plan carriers at the May 8, 2025 HSB meeting. The change is from The Hartford (Life, AD&D, Long-Term Disability) and Manhattan Life (Short-Term Disability) to Life Insurance Company of North America (“LINA”) (also known as New York Life) with policies effective January 1, 2026.

The RFP included minimum qualifications to bid, including no loss of coverage for all current plan participants, no disruption to disabled employees and active/in-process claims, no statement of health or medical evidence for current in-force benefit amounts and a required match to all union-negotiated (MOU) terms for employer-paid Group Life and Long-Term Disability insurances. The RFP results met expectations to exceed industry standards in areas such as best-in-class service and support for City and Court employees (employees) and families, and no-cost value-added services for employees, beneficiaries and employee families. The RFP result ensures financial stability through multi-year rate and premium guarantees across all life, AD&D and disability insurance benefits. The change to LINA, as the new life and disability benefits provider, is expected to deliver an exceptional experience for employees – including a 100% benefit increase to the guaranteed issue amount, up to $200,000 of coverage, for voluntary employee-paid Life for 2026 – as well as a total employer savings of almost $2M in 2026 premiums. Additionally, LINA has provided a five-year premium rate guarantee for Group Life, Supplemental Life, AD&D, and Long-Term Disability, and a three-year premium rate guarantee for Short-Term Disability insurance. The five-year premium guarantee for employer-paid Group Life and Long-Term Disability insurance extends the almost $2M annual employer (City) savings (compared to 2025 premiums) through the 2030 benefits year.

Summary of Projected 2026 Plan Year Costs

Table 3 below summarizes projected 2026 aggregate SFHSS plan costs across the plans available to active employees and retirees relative to 2025 projections for those plans where the employers subsidize the total plan cost. VSP Basic Plan (vision) costs are included in the medical plans' costs.

TABLE 3 — ALL FOUR EMPLOYERS Distribution of Aggregate Calendar Year 2026 Plan Costs ($ millions)	Aggregate Member Contributions (a)	Aggregate Employer Contributions (b)	Aggregate Plan Cost (a + b)	Member Contributions as a % of Aggregate Costs	Employer Contributions as a % of Aggregate Costs
Kaiser HMO	**$68.4**	**$577.2**	**$645.6**	**10.60%**	**89.40%**
$ Change	$6.5	$51.6	$58.1		
% Change	10.47%	9.83%	9.90%		
BSC HMOs/PPO	**$81.2**	**$549.4**	**$630.6**	**12.88%**	**87.12%**
$ Change	$3.7	$37.5	$41.1		
% Change	4.76%	7.32%	6.98%		
Health Net CanopyCare HMO	**$1.4**	**$13.1**	**$14.5**	**9.40%**	**90.60%**
$ Change	$0.0	$0.0	$0.0		
% Change	-0.33%	-0.29%	-0.29%		
Dental	**$3.8**	**$45.0**	**$48.8**	**7.71%**	**92.29%**
$ Change	$0.0	$5.3	$5.3		
% Change	0.00%	13.32%	12.17%		
LTD Insurance	**$0.0**	**$4.3**	**$4.3**	**0.00%**	**100.00%**
$ Change	$0.0	-$1.7	-$1.7		
% Change	0.00%	-28.91%	-28.91%		
Life Insurance	**$1.3**	**$1.4**	**$2.7**	**47.55%**	**52.45%**
$ Change	$0.0	-$0.3	-$0.3		
% Change	0.00%	-15.70%	-8.90%		
STD Insurance	**$1.0**	**$0.0**	**$1.0**	**100.00%**	**0.00%**
$ Change	$0.0	$0.0	$0.0		
% Change	0.00%	0.00%	0.00%		
Total	**$157.1**	**$1,190.4**	**$1,347.5**	**11.65%**	**88.35%**
$ Change	$10.2	$92.4	$102.6		
% Change	6.93%	8.41%	8.24%		

NOTES: Figures vary due to rounding; dental costs reflect active employees only (retiree-pay-all dental plan costs not included).

This year's projected aggregate medical cost increase of 8.33% (see page 5) is slightly lower than national benchmark levels for health care cost trend. Aon's 2025 National Health Care Trend Survey indicates combined medical/pharmacy expected cost increases of 9% into the 2026 plan year. The 8.33% increase for SFHSS in 2026 is higher than the California large counties experience for 2025 as documented in the SFHSS 10-County Survey (6.81%), as projected trends for 2026 are expected to be higher in general than during 2025.

Conclusion

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

Sincerely,

Michael A. Clarke, FSA, MAAA, FCA
Senior Vice President & Consulting Actuary, Aon Consulting, Inc.

cc: President and Members of the Health Service Board
Rey Guillen, Executive Director, San Francisco Health Service System

Appendix — CCSF Costs Only

TABLE 3a — CITY AND COUNTY OF SAN FRANCISCO ONLY (CCSF) Distribution of Aggregate Calendar Year 2026 Plan Costs ($ millions)	Aggregate Member Contributions (a)	Aggregate Employer Contributions (b)	Aggregate Plan Cost (a + b)	Member Contributions as a % of Aggregate Costs	Employer Contributions as a % of Aggregate Costs
Kaiser HMO	**$56.5**	**$462.9**	**$519.4**	**10.87%**	**89.13%**
$ Change	$5.4	$41.4	$46.8		
% Change	10.51%	9.82%	9.89%		
BSC HMOs/PPO	**$73.3**	**$486.7**	**$560.0**	**13.09%**	**86.91%**
$ Change	$3.4	$33.4	$36.8		
% Change	4.85%	7.36%	7.02%		
Health Net CanopyCare HMO	**$1.0**	**$9.3**	**$10.3**	**9.63%**	**90.37%**
$ Change	$0.0	$0.0	$0.0		
% Change	-0.35%	-0.30%	-0.30%		
Dental	**$3.7**	**$44.5**	**$48.2**	**7.71%**	**92.29%**
$ Change	$0.0	$5.2	$5.2		
% Change	0.00%	13.33%	12.17%		
LTD Insurance	**$0.0**	**$4.2**	**$4.2**	**0.00%**	**100.00%**
$ Change	$0.0	-$1.7	-$1.7		
% Change	0.00%	-28.91%	-28.91%		
Life Insurance	**$1.3**	**$1.4**	**$2.7**	**47.55%**	**52.45%**
$ Change	$0.0	-$0.3	-$0.3		
% Change	0.00%	-15.70%	-8.90%		
STD Insurance	**$1.0**	**$0.0**	**$1.0**	**100.00%**	**0.00%**
$ Change	$0.0	$0.0	$0.0		
% Change	0.00%	0.00%	0.00%		
Total	**$136.8**	**$1,009.0**	**$1,145.8**	**11.93%**	**88.07%**
$ Change	$8.8	$78.0	$86.8		
% Change	6.84%	8.38%	8.19%		

NOTES: Figures vary due to rounding; dental costs reflect active employees only (retiree-pay-all dental plan costs not included).