June 15, 2015

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

RE: January 1, 2016 to December 31, 2016 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) with regard to the completed rates and contribution setting process for the plan year from January 1, 2016 to December 31, 2016. This process was concluded on June 11, 2015 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 approved by four members of the Health Service Board during their meeting on June 11, 2015. This report will reference attached exhibits, as well as tables embedded in this letter.

In our opinion, the rates and contribution process was completed in a comprehensive manner. Specifically it is our professional opinion that:

- The fully 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 Health Plan (UHC), Delta Dental plan for active employees (Delta) and the Blue Shield of California 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 Patient Protection and Affordable Care Act (PPACA)

In 2015 and 2016, additional provisions of Patient Protection and Affordable Care Act (PPACA) 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 the provisions that will have the greatest effect.

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PPACA Reporting Requirements

Under PPACA, employers are required to provide reporting to both employees as well as the Internal Revenue Service (IRS). 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 will be filed beginning with 2015 calendar year information on Forms 1094 and 1095. Reporting is due to the employee by January 31 following the close of the calendar year, e.g., 2015 information is due to employees by January 31, 2016. Since HSS represents more than 250 employees, electronic reporting is due to the IRS by March 31 following the close of the calendar year, e.g., 2015 information is due to the IRS by March 31, 2016.

HSS is in the process of identifying and collecting the data elements needed for reporting as well as establishing a process for the creation and delivery of the required forms.

PPACA Automatic Enrollment Requirement (deferred indefinitely)

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 has indefinitely postponed final guidance on automatic enrollment. While employers do not need to comply with this requirement until these final regulations are in effect, HSS is preparing for implementation.

PPACA Legislative Fees

As a result of 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 2016 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 Insurance Tax (HIT): This tax impacts all fully insured or flex-funded plans including vision and dental 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 $16.24 million in premiums or an increase of 2.10% which is paid to insurers for all HSS fully insured and flex-funded plans in 2016 for all employers. (See Table 1a.) The additional

premiums for CCSF alone are $12.82 million. (See Table 1b.) The fee is collected by the Internal Revenue Service.

- Patient Centered Outcomes Research Institute (PCORI) Fee: Beginning in 2013, a $2.00 charge per enrollee per year was assessed to all participants (actives, retirees without Medicare, and retirees with Medicare) in medical-only health plans. The fee was $2.08 per enrollee per year in 2015 and is expected to increase to approximately $2.25 per enrollee per year in 2016. Aon Hewitt estimates that this tax will result in an additional $0.28 million in 2016 premiums/premium equivalents or a 0.035% increase for all employers. (See Table 1a.) The CCSF increase is expected to increase by $0.21 million. (See Table 1b.) This fee is expected to increase with inflation until 2019 when the fee will stop being assessed. The fee is collected by the Internal Revenue Service.
- Transitional Reinsurance Fee: In 2016, a $27.00 charge per enrollee per year will be assessed to all participants where Medicare is not the primary payer. This is a decrease from the $44.00 charge per enrollee per year assessed in 2015. Aon Hewitt estimates that this tax will result in an additional $2.40 million in 2016 premiums/premium equivalents or a 0.31% increase for all employers. (See Table 1a.) The CCSF increase is estimated to be $1.85 million, (See Table 1b.) This fee is expected to be eliminated beginning with 2017. This fee is collected by the Department of Health and Human Services to subsidize the uninsured for coverage from State Health Insurance Exchanges.

Total expenditures on medical premiums/premium equivalents are $718.6 million. Of this total, the legislative fees and taxes are $18.92 million or 2.6% of total expenditure. The following tables summarize the estimated aggregate cost of each of these legislative fees for 2016 for all four employers served by the Trust (Table 1a) and CCSF only (Table 1b):

Table 1a
2016 Legislative Fees ($ millions) All Employers

Fee	City Health Plan (UHC)	Kaiser	Blue Shield	Dental	VSP	Total
HIT	$0.00	$3.64	$12.50	$0.01	$0.09	$16.24
PCORI	$0.02	$0.15	$0.11	N/A	N/A	$0.28
Transitional Reinsurance	$0.07	$1.33	$1.00	N/A	N/A	$2.40
Total	**$0.09**	**$5.12**	**$13.61**	**$0.01**	**$0.09**	**$18.92**

Table 1b
2016 Legislative Fees ($ millions) CCSF Only

Fee	City Health Plan (UHC)	Kaiser	Blue Shield	Dental	VSP	Total
HIT	$0.00	$2.69	$10.04	$0.01	$0.08	$12.82
PCORI	$0.01	$0.11	$0.09	N/A	N/A	$0.21
Transitional Reinsurance	$0.03	$0.99	$0.83	N/A	N/A	$1.85
Total	**$0.04**	**$3.79**	**$10.96**	**$0.01**	**$0.08**	**$14.88**

City Contributions under the 10-County Survey

According to the City Charter Section A8.428, the City's contribution towards medical benefits is determined by the results of a survey of the premium contributions (in terms of dollar amount) provided by the ten most populous counties in California, excluding San Francisco. In the June 2014 collective bargaining, the 10-County Survey (Survey) was eliminated in the calculation of premium contributions for active employees in exchange for a percentage-based employee premium contribution. The Survey is still used as a basis for calculating all retiree premium contributions. For the 2016 plan year, the Survey, based on 2015 rates, determined that the average monthly contribution increased 2.02% from $567.80 to $579.24. Exhibit 1 presents the individual county responses from the Survey.

Year-Over-Year Health Plan Cost Comparison

Annual aggregated costs for the three medical plans offered by HSS (City Health Plan (UHC), Kaiser Permanente, and Blue Shield of California) are shown in Table 2.

Table 2
January 1, 2016 to December 31, 2016 Aggregate Medical Cost ($ millions)

	Member Contributions	Employer Contributions	Aggregate Plan Cost
Current Rates	**$78.6**	**$612.0**	**$690.6**
Final Renewal Rates	**$79.7**	**$638.9**	**$718.6**
$ Difference	$1.1	$26.9	$28.0
% Difference	1.40%	4.40%	4.05%

The above table illustrates an increase in aggregate plan costs totaling $28.0 million, or 4.05%, for the three medical plans (including vision cost and HSS Communications and Healthcare Sustainability expense) for the 2016 plan year. This increase in costs will be split 4%/96% between the members and employers with member contributions increasing $1.1 million and employer contributions increasing $26.9 million.

Current City and County (CCSF) Contribution Strategy

As of 2015, there are two negotiated contribution algorithms for CCSF covered employees. 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 Health Service System (HSS), the City shall contribute ninety-three percent (93%) of the total health insurance premium/premium equivalent provided. However, the City'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 HSS, the City shall contribute ninety-three percent (93%) of the total health insurance premium/premium equivalent provided. However, that the City'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 HSS, the City shall contribute eighty-three (83%) of the total health insurance premium/premium equivalent provided. However, that the City'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 HSS, the City 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 HSS, the City shall contribute ninety-six percent (96%) of the total health insurance premium/premium equivalent provided. However, that the City'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 HSS, the City shall contribute eighty-three (83%) of the total health insurance premium/premium equivalent provided. However, that the City'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.

Aon Hewitt produced two sets of rate cards, both approved by the HSB for plan year 2016. One rate card specified member contributions under the 93/93/83 model and the other rate card under the100/96/83 model.

Rates, Contributions, and Benefits for HMOs

Consistent with the 2015 plan year, two HMO plans will be offered to HSS members for plan year 2016. These plans are offered by Kaiser Permanente and Blue Shield of California.

Plan Design Changes for HMOs

No plan design changes were recommended to the Rates and Benefits Committee and the HSB.

- **Kaiser Permanente (Fully Insured)**

  The HSB adopted no plan design changes for the Kaiser Permanente plan.

  Kaiser Permanente is currently on the second year of a two-year rate guarantee; the final negotiated rate change for Kaiser Permanente is an overall decrease of 2.00% from 2014 rates for actives and retirees without Medicare through 12/31/2016. For retirees with Medicare the rate

change is increase of 2.13% (including the reconciliation for plan year 2015). This results in an overall estimated increase of $1.0 million annually based on May 2015 membership.

The aggregate cost for Kaiser Permanente for the 2016 plan year is projected at $339.5 million, with $36.3 million in member contributions and $303.2 million in employer contributions. Table 3 (page 9) provides an overview of annualized costs.

- **Blue Shield of California (Flex-funded)**

  The HSB adopted no plan design changes for the Blue Shield of California plan.

  On January 1, 2013, the funding arrangement for actives and retirees without Medicare switched from fully insured to flex-funded. Claims experience highlighted by increased cost for specialty pharmacy cost led to a required increase of 11.5% for the premium equivalents for actives and early retirees for plan year 2016. Retirees and spouses with Medicare will continue to be offered the 65 Plus Medicare Advantage Prescription Drug (MAPD) HMO and the Access+ Medicare coordinated HMO through Blue Shield of California. For plan year 2016 Medicare costs are reduced $0.8 million over plan year 2015 based on May 2015 membership.

  The aggregate cost for the Blue Shield of California HMO for the 2016 plan year is projected at $341.0 million, with $39.1 million in member contributions and $301.9 million in employer contributions based on May 2015 membership. Table 3 (page 9) provides an overview of annualized costs.

HMO Contributions

The contribution models for the HMO active and retired members are summarized in exhibits 2a-2b and 3a-3c.

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

The City Health Plan 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 Health Plan's recent claims data. This analysis was considered in conjunction with overall industry and normative data when determining the premium equivalent levels for the 2016 plan year.

No plan design changes were recommended to the Rates and Benefits Committee and the HSB.

The UHC administration fees increased slightly from 2015 to 2016.

The final monthly premium equivalents with no plan design changes result in an overall decrease of 8.88%. For actives and retirees without Medicare, the decreases are 25.2%, 21.2%, respectively. These decreases in premium equivalents are due to underwriting gains caused by lower utilization that the City Health Plan produced during the 2014 plan year and by a one-time Health Service Board subsidy of $5.4 million see below.

For retirees with Medicare the increase is 3.2%. The pharmacy portion of the Medicare rate is covered by a fully insured Employer Group Waiver Plan (EGWP) product. This rate increased to $171.09 from $156.96 per retiree per month.

At the end of 2014, over $10.9 million of underwriting gains were placed into the City Health Plan Stabilization Reserve which increased the overall amount in the reserve to $25.8 million. Per the Health Service Board's Self-Funded Plans' Stabilization Policy, one-third of the amount in the Stabilization Reserve ($8.6 million) was spread across all rating tiers to lower the City Health Plan premium equivalents. Additionally, at the HSB May 14, 2015 meeting, the Board elected to support a one-time buy down in the amount of $5.4 million from the Stabilization Reserve to bring active and early retiree member contributions more in line with the Blue Shield of California and Kaiser Permanente programs.

Changes in monthly premium equivalents for the City Health Plan are summarized in Exhibit 4. Included in the premium equivalent rate, pursuant to the Health Service Board's Self-Funded Plans' Stabilization Policy, is the application of the claims stabilization amount.

The aggregate cost for the City Health Plan for the 2016 plan year is projected at $38.1 million, with $4.3 million in member contributions and $33.8 million in employer contributions. This results in an overall estimated decrease of $3.7 million annually. Table 3 (page 9) provides an overview of annualized costs.

Changes in employee and retiree contributions for City Health Plan (UHC) are summarized in Exhibits 5a and 5b. These contributions were determined in accordance with the City Charter which include the most recent 10-County Survey result of $579.24, if applicable, and adjusts for the 93/93/83 and 100/96/83 contribution models.

The HSS will offer a new UHC fully insured National Medicare Advantage Prescription Drug (MAPD) PPO program to the HSS Medicare retirees in 2016 please see Exhibit 11.

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, 2016, VSP vision plan rates will increase 1% from 2015 levels. The aggregate cost for the VSP vision plan for the 2016 plan year is projected at $4.7 million. VSP vision plan costs are summarized in Exhibit 6.

Rates, Contributions, and Benefits for Dental Plans

Three dental plans are offered to active 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 a closed panel 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 was reduced $0.03 per employee per month from the 2015 plan year.

The aggregate premium equivalent for the self-funded Delta Dental PPO plan for active employees shows a 2.9% reduction for plan year 2016. Since this is a self-insured plan, the Health Insurance Tax does not apply.

The Delta Dental PPO plan for retirees, Delta Care USA dental plans for active employees and retirees, and Pacific Union Dental plans for active employees and retirees are all fully insured. The fully insured premiums for the Delta Dental PPO plan for retirees accepted a 6% premium reduction for plan years 2016 and 2017. This reduction includes the coverage increase for a diagnostic and preventive care fee waiver. The fully insured premiums for the Delta Care USA dental plans for active employees and retirees are unchanged from the 2015 plan year premiums and a rate pass was extended through December 31, 2018. The fully insured premiums for the Pacific Union plans were given a rate pass through December 31, 2016.

For the 2016 plan year, the City will contribute the total premium towards each of the dental HMO plans for CCSF employees. For the self-funded Dental PPO plan, the City will contribute the monthly premium equivalent minus employee contributions of $5.00, $10.00, and $15.00 for Employee Only, Employee plus One, and Employee plus Two or more respectively. The member contributions for Delta Dental PPO plan for retirees, Delta Care USA dental plans for actives and retirees, and Pacific Union Dental plans for actives and retirees remain unchanged from the 2015 plan year. Pursuant to the Health Service Board's Self-Funded Plans' Stabilization Policy, a claims stabilization amount $1.3 million has been applied this year.

Changes in dental cost for the Delta Dental PPO plan, Delta Care USA plan, and Pacific Union Dental plans are summarized in Exhibit 7, 8, and 9 respectively.

The aggregate dental plan cost for actives for the 2016 plan year is projected at $45.7 million, with $3.5 million in member contributions and $42.2 million in employer contributions. There is no increased cost to the City for dental care. Table 3 provides an overview of annualized costs.

Life and Long Term Disability (LTD) Insurance

Life and long term disability premiums remain unchanged from the 2015 rates; however the 2015 MOU negotiations greatly increased the number of covered employees. The aggregate life and LTD plan cost for the 2016 plan year is projected at $7.8 million, with $0.2 million in member contributions and $7.6 million in employer contributions. Annualized cost comparisons are summarized in Exhibit 10.

Summary of Projected 2016 Plan Year Costs

Illustrated below, in Table 3, is a summary of how projected 2016 aggregate HSS plan costs are distributed across the different plans that are available to active employees and retirees. Costs are shown only for those plans where the employers subsidize the total premium/premium equivalent cost. The premium costs associated with the VSP vision care plan are included in the medical plans' costs.

TABLE 3 *
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	**$36.3**	**$303.2**	**$339.5**	**10.70%**	**89.30%**
$ Increase	$0.1	$0.9	$1.0		
% Increase	0.31%	0.29%	0.29%		
Blue Shield HMO	**$39.1**	**$301.9**	**$341.0**	**11.46%**	**88.54%**
$ Increase	$4.4	$26.4	$30.7		
% Increase	12.65%	9.56%	9.91%		
City Plan	**$4.3**	**$33.8**	**$38.1**	**11.21%**	**88.79%**
$ Increase	-$3.4	-$0.3	-$3.7		
% Increase	-44.63%	-0.84%	-8.91%		
**Dental ** **	**$3.5**	**$42.2**	**$45.7**	**7.62%**	**92.38%**
$ Increase	$0.0	-$1.4	-$1.4		
% Increase	0.00%	-3.12%	-2.89%		
LTD	**$0.0**	**$6.7**	**$6.7**	**0.00%**	**100.00%**
$ Increase	$0.0	$1.0	$1.0		
% Increase	0.00%	0.00%	17.54%		
Life	**$0.2**	**$0.9**	**$1.1**	**19.64%**	**80.36%**
$ Increase	$0.1	$0.5	$0.6		
% Increase	66.67%	0.00%	110.53%		
Total	**$83.4**	**$688.8**	**$772.2**	**10.80%**	**89.20%**
$ Increase	$1.2	$27.1	$28.2		
% Increase	1.41%	4.09%	3.80%		

** Figures vary due to rounding*

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

This year's projected aggregate cost increase of 3.80% compares favorably with available benchmark information. The "2015 Health Care Trend Survey" published by Aon indicates medical and pharmacy cost increases in the range of 5% to 7%.

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

cc: President and Members of the Health Service Board
Catherine Dodd, PhD, RN, Director, Health Service System