File No. 100135

Committee Item No. 8
Board Item No. ______

COMMITTEE/BOARD OF SUPERVISORS

AGENDA PACKET CONTENTS LIST

Committee BUDGET AND FINANCE Date 2/24/10

Board of Supervisors Meeting Date ______

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Completed by: Gail Johnson Date 2/19/10
Completed by: ______ Date ______

An asterisked item represents the cover sheet to a document that exceeds 25 pages. The complete document is in the file.

FILE NO. 100135 RESOLUTION NO. ___________

1 [Establishing Monthly Contribution Amount.]

2

3 **Resolution establishing monthly contribution amount to Health Service Trust**
4 **Fund.**

5

6 WHEREAS, Under Section A8.423 of Appendix A to the City Charter, the Health
7 Service Board (the "HS Board") is required to conduct a survey of the ten counties in
8 the State of California, other than the City and County of San Francisco, having the
9 largest populations to determine the average contribution made by each such county
10 toward the providing of health care plans, exclusive of dental or optical care, for each
11 employee of such county; and,
12 WHEREAS, Under Section A8.423, the HS Board is required to certify to the
13 Board of Supervisors "the average contribution" as determined by the survey; and,
14 WHEREAS, According to the California Department of Finance, the ten most
15 populous counties in the State of California other than San Francisco (in descending
16 order of population) are: Los Angeles, San Diego, Orange, Riverside, San Bernardino,
17 Santa Clara, Alameda, Sacramento, Contra Costa and Fresno (collectively, the
18 "Survey Counties"); and,
19 WHEREAS, According to the survey of each of the Survey Counties which was
20 completed on December 10, 2009, a copy of which is on file with the Clerk of the Board
21 of Supervisors in File No. , which is hereby declared to be a part of this
22 resolution as if set forth fully herein, the HS Board has determined that "the average
23 contribution" is the sum of **four hundred seventy-two dollars and eighty-five cents**
24 **($472.85);** and,

25

1 WHEREAS, The HS Board has certified "the average contribution" to the Board
2 of Supervisors as required by Charter Section A8.423; now, therefore, be it
3 RESOLVED, That the certification by the HS Board of "the average contribution"
4 is hereby accepted and shall constitute the monthly amount to be contributed to the
5 Health Service Trust Fund for Fiscal Year 2010-2011 under the Charter.
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Items 7 & 8 Files 10-0134 & 10-0135	Department(s): Health Service System (HSS)

EXECUTIVE SUMMARY

Legislative Objective

- The proposed ordinance (File 10-0134) would amend Section 16.703 of the City's Administrative Code, to (a) approve the FY 2010-2011 health plans offered by the Health Service System (HSS) to its members and (b) set the employer's and members' contributions for the monthly health plan premiums.
- The proposed resolution (File 10-0135) would establish the monthly employer contribution to the Health Service System Trust Fund for FY 2010-2011. The monthly employer contribution is based on the results of the ten-county survey conducted by the Health Service Board, as required by the Charter.

Fiscal Impact

- Based on the results of the ten-county survey conducted by the Health Service Board, the employer's FY 2010-2011 contribution to the Health Service System Trust Fund is $472.85 per member per month, which is an increase of $23.48 or 5.2 percent from the FY 2009-2010 contribution of $449.37 per member per month.
- The City's total estimated cost is $323,116,874 for FY 2010-2011 health and dental premium contributions to the Health Service System Trust Fund using the proposed FY 2010-2011 monthly premium rates, including General Fund costs of $185,248,468. The estimated $323,116,874 is $9,149,763, or 2.9 percent, more than the total cost of $313,967,111 for health and dental premium contributions based on the FY 2009-2010 monthly premium rates.

Recommendation

- Approve the proposed ordinance and resolution.

CHARTER REQUIREMENTS

The Health Service System (HSS) administers non-pension benefits: health, dental, vision, and other benefits that may be available to City employees, such as life and disability insurance. The Health Service Board oversees the Health Service System and adopts the annual health plans and employer and member[1] contributions to monthly premiums.

Under Section A8.423 of the City Charter, 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 employer's contribution for member health plans' monthly premiums, which is equal to the average of the contributions made by each of the ten counties.

DETAILS OF PROPOSED LEGISLATIONS

File 10-0134: The proposed ordinance would amend Section 16.703 of the City's Administrative Code, to (a) approve the FY 2010-2011 health plans offered by the Health Service System (HSS) to its members and (b) set the employer's and members' contributions for the monthly premiums of such plans, as discussed below.

The Health Service Board approved these plans and employer's and members' contributions to the plans' monthly premiums on January 14, 2010.

File 10-0135: The proposed resolution would approve the FY 2010-2011 employer's contribution to the Health Service System Trust Fund[2] of $472.85 per member per month, which is an increase of $23.48 or 5.2 percent from the FY 2009-2010 employer's contribution of $449.37 per member per month. The proposed FY 2010-2011 employer's monthly contribution is based on the results of the ten-county survey, as shown in Attachment I, provided by HSS.

THE FY 2010-2011 HEALTH, DENTAL AND VISION PLANS' MONTHLY PREMIUMS

Proposed Monthly Premiums and Benefits for the Health Plans and Vision Plans

In FY 2010-2011, HSS will offer three health plans, including one self-funded health plan, the City Health Plan, and two plans provided through third-party insurers, Kaiser and Blue Shield. The City Health Plan is a preferred provider organization, or PPO, which provides services through a network of providers. Both Kaiser and Blue Shield are health maintenance organizations, or HMOs, which provide services through a closed panel of providers. HSS will offer one vision plan provided through third-party insurer, VSP Vision.

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[1] HSS employers include the City and County of San Francisco, the San Francisco Unified School District, the San Francisco Community College District, and the San Francisco Superior Court. HSS members are active and retired employees of these employers, their dependents, and members of eligible boards and commissions. Dependents include children, spouses, domestic partners, surviving spouses of deceased employees, and other legal dependents.

[2] Under the Charter, the Health Service System Trust Fund receives all contributions and pays all health plan expenses.

As of January 1, 2010, there are approximately 57,069 active and retired HSS members, as shown in Table 1 below.[3]

Table 1: Active and Retired HSS Members

	Active Employees	Retired Employees	Total	Percent
City Health Plan	1,559	5,424	6,983	12.24%
Kaiser	16,543	8,911	25,454	44.60%
Blue Shield	18,732	5,900	24,632	43.16%
Total	**36,834**	**20,235**	**57,069**	**100.00%**

Source: Health Service System, as of January 1, 2010

Monthly Premium Increases for the Employer and Employees: Both the employer and members contribute to the total monthly premium. The proposed FY 2010-2011 monthly premiums for the three health plans and the vision plan are shown in Table 2 below for single employees (without dependents) and are further detailed in Attachment II, provided by HSS. Members enrolled in one of the three HSS health plans also receive vision benefits. The monthly VSP Vision premium is included in the total monthly premium for each of the three health plans, shown in Table 2 and in Attachment II.

Table 2: Comparison of FY 2009-2010 and FY 2010-2011 for the Medical and Vision Monthly Premiums for Single Employees

	Proposed FY 2010-2011	FY 2009-2010	Increase (Decrease)	Percent Change
City Health Plan	$926.66	$808.28	$118.38	14.6%
Kaiser	481.69	464.36	17.33	3.7%
Blue Shield	593.73	532.89	60.84	11.4%

Source: Health Service System

As shown in Table 2, the total City Health Plan monthly premium for single employees is increasing by $118.38 or 14.6 percent, from $808.28 in FY 2009-2010 to $926.66 in FY 2010-2011. As noted on page 1 of the January 29, 2010 letter to the Board of Supervisors from Mercer (Attachment III), the HSS consultant and actuary, the monthly premium for the City Health Plan "represents the best estimate of future expenditures based on the information available at the time they were developed".

Also shown in Table 2, (a) the total Blue Shield monthly premium for single employees is increasing by $60.84 or 11.4 percent, from $532.89 in FY 2009-2010 to $593.73 in FY 2010-2011, and (b) the total Kaiser monthly premium for single employees is increasing by $17.33 or 3.7 percent, from $464.36 in FY 2009-2010 to $481.69 in FY 2010-2011. As noted on page 1 of Attachment III, the insured premiums and administrative fees agreed to with Kaiser and Blue Shield "represent a fair price given the services provided and the risks insured".

[3] HSS has a total of approximately 107,078 members of the City and County of San Francisco, San Francisco Unified School District, Superior Court, and the Community College District, which includes 57,069 active and retired employees and 50,009 dependents.

HSS is increasing mental health and substance abuse services in each of the three health plans to comply with the Federal Mental Health Parity Act of 2009, which became effective on October 3, 2009 (see Federal Mental Health Parity Act of 2009 in the Policy Analysis section below).Consequently, as noted on page 2 of Attachment III, the health plans' monthly premiums were presented and adopted by the Health Services Board.

The Health Service Board recommends three additional changes to the FY 2010-2011 health plans, which includes (a) increasing the copayment for doctor visits under the Blue Shield and Kaiser HMO plans[4], (b) increasing the emergency room copayment under the Blue Shield and Kaiser HMO plans[5] and (c) charging a $15 copayment for preventive services, which includes routine physicals, well baby care, gynecologic exams, and pre/post-natal care under the Blue Shield plan. The City Health Plan did not have any additional benefit changes.

Monthly Premium Increases for the Employer: The increases to the monthly premiums for single employees (without dependents) of the three health plans, as shown in Table 2 above, are shared by both the employer and the members. As shown in Table 3 below and also further detailed in Attachment IV, provided by HSS, the increase to the employer's contribution is $23.48, or 5.2 percent. As noted above, the increase in the employer's FY 2010-2011 contribution is based on the results of the ten-county survey.

Table 3: Comparison of FY 2009-2010 and FY 2010-2011 Medical and Vision Monthly Premiums for Single Employees by Employer and Employee Contribution

	Total Contribution	Employee Contribution				Employer Contribution			
	Proposed FY 2010-2011	Proposed FY 2010-2011	FY 2009-2010	Increase (Decrease)	Percent Change	Proposed FY 2010-2011	FY 2009-2010	Increase (Decrease)	Percent Change
City Health Plan	$926.66	$453.81	$358.91	$94.90	26.4%	$472.85	$449.37	$23.48	5.2%
Kaiser	481.69	$8.84	14.99	(6.15)	(41.0%)	$472.85	$449.37	$23.48	5.2%
Blue Shield	593.73	120.88	83.52	$37.36	44.7%	$472.85	$449.37	$23.48	5.2%

Source: Health Service System

Proposed Monthly Premiums and Benefits for the Dental Plans

In FY 2010-2011, HSS will offer three dental plans including one PPO plan, the Delta Premier, and two HMO plans, DeltaCare USA and UHC Dental. The Delta Premier Plan is a dental PPO with a network of preferred providers. The Delta Premier plan is (a) self-insured through HSS for active members and (b) fully insured for retirees. The DeltaCare USA and UHC Dental Plans are dental HMOs with a closed panel of providers and are fully insured plans.

[4] In the Blue Shield HMO plan, the doctor visit copayment will increase by $5 or 33.3 percent, from $15 to $20. In the Kaiser HMO plan, the doctor visit copayment will increase by $5 or 50 percent, from $10 to $15.

[5] In the Blue Shield and Kaiser HMO plans, the emergency room copayment will increase by $50 or 100 percent, from $50 to $100.

Employers, including only the City and the Superior Court (not including the San Francisco Unified School District and the Community College District), pay the dental plan premiums for active members. The employer contributes the average cost of employees' monthly dental plan premiums. As shown in Table 4 and Attachment V, the employer's contribution for dental benefits increased from $116.55 per member per month in FY 2009-2010 to $131.94 per member per month in FY 2010-2011, an increase of $15.39 per month, or approximately 13.2 percent.

Table 4: Comparison of FY 2009-2010 and FY 2011-2011 for the Dental Monthly Premiums for Single Employees

	Proposed FY 2010-2011	FY 2009-2010	Increase	Percent Change
Delta Premier, DeltaCare USA and UHC Dental.	$131.94	$116.55	$15.39	13.2%

Source: Health Service System

FY 2010-2011 CONTINGENCY AND STABILIZATION POLICIES AND AMOUNTS

In October 2007, the Health Service Board approved policies designating a portion of the Health Service System Trust Fund balance to: (a) provide contingencies for HSS's self-funded City Health Plan and self-funded employee dental plan and (b) stabilize City Health Plan and employees' dental plan premium increases by including prior years' premium revenue surpluses or shortfalls when calculating required premiums in the new plan year.

Contingency Fund: The Contingency Fund is intended to protect against shortfalls in the Health Service System Trust Fund's claims reserve for the self-funded City Health Plan and employee dental plan, resulting from higher than expected claims compared to premium payments. For the past two fiscal years, HSS has reviewed the contingency policy amount annually to assess the adequacy of the contingency to meet potential claims liability, and will increase the contingency amount as necessary.

As shown in Table 5 below, the Contingency Fund amount has increased every year since FY 2008-2009.

Table 5: Contingency Fund Increases

	City Health Plan	Dental Plan	Total	Increase	Percent Change
FY 2008-2009	$10,200,000	$3,000,000	$13,200,000	--	--
FY 2009-2010	$10,700,000	$3,100,000	$13,800,000	$600,000	4.54%
FY 2010-2011	$10,800,000	$3,300,000	$14,100,000	$300,000	2.17%

Source: Health Service System

According to Ms. Robin Courtney, Chief Financial Officer of HSS, and shown in Table 5 above, HSS will increase the total contingency amount by $300,000, or 2.17 percent, from $13,800,000 in FY 2009-2010 to $14,100,000 for FY 2010-2011. The increases to the contingency amounts has already been included in the FY 2010-2011 City Health Plan and dental monthly premiums as listed in Table 2 above and Table 4 above.

The monies collected for the Contingency Fund is included in the Health Service System Trust Fund balance (see Health Service System Trust Fund Balance in Fiscal Analysis section below).

Stabilization Policy: In addition to the Contingency Fund, the Health Service Board has adopted a stabilization policy. Under this stabilization policy, HSS will incorporate the City Health Plan's actual premium revenue[6] surpluses or shortfalls from a prior audited year, over a period of three years, when calculating required premiums in the new plan year. For example, the City Health Plan's actual premium revenue surpluses from FY 2008-2009 have been incorporated into the monthly premium amounts for FY 2010-2011 and will be incorporated into the monthly premium amounts for FY 2011-2012 and FY 2012-2013 as an overall reduction to the monthly premium amounts. HSS will also incorporate the City's self-funded employee dental plan's actual premium revenue surpluses or shortfalls in the prior audited year when calculating required premiums in the new plan year. For example, the dental plan's actual premium revenue shortfalls from FY 2008-2009 have been incorporated into the monthly premium amount for FY 2010-2011 as an overall increase to the monthly premium amount.

In FY 2009-2010 the Health Service Board approved a $1,100,000 stabilization amount. The Health Service Board has calculated and approved a $100,000 stabilization amount for FY 2010-2011, which is a $1,000,000 decrease from the $1,100,000 approved in FY 2009-2010. The $1,000,000 stabilization amount in FY 2010-2011 includes (a) a reduction of $1,200,000 that has already been included in the FY 2010-2011 City Health Plan monthly premiums as listed in Table 2 above, and (b) an increase of $1,300,000 that has already been included in the FY 2010-2011 dental monthly premium rate as listed in Table 4 above.

FISCAL ANALYSIS

Fiscal Impact of the FY 2010-2011 Health Plan Premium Contributions

According to the Controller's Office, the City's total estimated cost is $323,116,874 for FY 2010-2011 health and dental premium contributions to the Health Service System Trust Fund using the City's FY 2010-2011 proposed monthly premium rates, including General Fund costs of $185,248,468. This estimated $323,116,874 is $9,149,763 or 2.9 percent more than the total cost of $313,967,111 for health and dental premium contributions based on the City's FY 2009-2010 monthly premium rates.

Health Service System Trust Fund Balance

The FY 2008-2009 financial audit, conducted by a private auditing firm, KPMG LLP, found that the Health Service System Trust Fund in FY 2008-2009 had decreased by $10,156,290, or 43.1 percent, from FY 2007-2008, as shown below.

Fund Balance as of June 30, 2009[7]	$13,400,446
Fund Balance as of June 30, 2008	23,556,736
Decrease	($10,156,290)

[6] Premium revenue is the actual amount of monthly premium collected less the actual amount of health expenses and administrative costs claimed.

[7] Does not include the Contingency Fund amount.

According to the Health Service System's audited financial statements, this decrease in the Trust Fund balance resulted from (a) higher than expected claims costs under the City Health Plan and self-funded dental plan, (b) premium payment costs to close out the PacifiCare plan discussed below, and (c) other reductions.

POLICY ISSUES

Implementation of the Federal Mental Health Parity Act of 2009 Adds New Mental Health and Substance Abuse Benefits and Increases the Monthly Health Plan Premium

Effective on October 3, 2009, the Federal Mental Health Parity Act of 2009 requires group health plans with more than 50 employees to provide the same level of mental health/substance use benefits as medical/surgical benefits. The law requires that such group health plans eliminate any day visit limits or financial maximums that have been imposed on mental health or substance use benefits if the limits or maximums are more restrictive than the predominant requirements and limitations placed on medical/surgical benefits. As a result of complying with the Federal Mental Health Parity Act of 2009, all three health plans offered by HSS, including the City Health Plan, Kaiser and Blue Shield, (a) eliminated limitations of mental health services, and/or (b) changed copayments for mental health/substance use visits to be equal to copayments of medical and surgical visits.

Changes to the City Health Plan include the elimination of (a) the 25 visits per year limitation for combined network and out-of-network services for mental health and/or substance abuse outpatient therapy, (b) the 60 days per year limitation for two courses of treatment per lifetime for networks and non-network benefits for inpatient chemical dependency rehabilitation, (c) the 30 medically certified days per year for non-Emergency inpatient detoxification, and (d) the 30 days per year for network and non-network benefits for any combination of mental health services and/or substance abuse inpatient hospitalization services.

Changes to the Blue Shield HMO Plan include (a) the elimination of the 60 visits per year limitation for outpatient mental health and/or substance abuse, (b) the elimination of the 30 days per year limitation for inpatient substance abuse therapy, (c) a charge of $20 mental health outpatient therapy copayments for both severe and non-severe visits, (d) a charge of $20 substance abuse outpatient therapy copayments, and (e) the application of mental health benefits to the out-of-pocket maximum.

Changes to the Kaiser HMO Plan include the elimination of (a) the 45 days per year limitation for inpatient mental health hospitalization, (b) the 20 visits per year limitation for outpatient mental health therapy, (c) the 60 days per calendar year, not to exceed 120 days in any 5-year period limitation for substance abuse transitional residential recovery service, and (d) the 30 days per calendar year rehabilitation limitation for substance abuse.

HSS is Required to Reimburse PacifiCare due to the Close out of the PacifiCare Flex Funded Plan in FY 2008-2009

In FY 2007-2008, HSS began offering a fourth plan, PacifiCare, in addition to the City Health Plan, Kaiser, and Blue Shield. PacifiCare is a "flexibly funded" HMO. Under the contract

between HSS and PacifiCare, if actual health and administrative expenses incurred by HSS members exceed the premiums paid to PacifiCare, which included both the employer and member contributions, HSS was required to reimburse PacifiCare up to approximately 120 percent of the premium payment. HSS stopped offering PacifiCare at the end of FY 2008-2009, and HSS members, previously enrolled in PacifiCare, subsequently enrolled in the City Health Plan, Kaiser, or Blue Shield plans by July 1, 2009. Although HSS stopped offering PacifiCare in FY 2008-2009, HSS is required to reimburse PacifiCare up to 120 percent of the premiums paid in FY 2008-2009, if actual health and administrative expenses exceeded such premiums, referred to as a PacifiCare close-out payment.

Ms. Courtney advises that in May of 2009, PacifiCare estimated that the FY 2008-2009 close-out payment was $4,050,000. HSS planned to pay the FY 2008-2009 PacifiCare close-out payment by adding a "flex-funded close down amount" to the FY 2009-2010 and FY 2010-2011 Kaiser, Blue Shield and City Health Plan monthly premiums. According to Ms. Courtney, HSS has already generated $2,950,000 from such additional FY 2009-2010 monthly premiums. According to Ms. Courtney, the balance of $1,100,000 ($4,050,000 less $2,950,000) was added to the FY 2010-2011 monthly premiums to generate the remaining amount needed for the PacifiCare FY 2008-2009 close-out payment.

In February of 2010, PacifiCare provided HSS with the actual FY 2008-2009 PacifiCare expenditures, premium payments and calculated close-out payment. According to Ms. Courtney, the actual health and administrative expenses of members enrolled in PacifiCare in FY 2008-2009 was $45,995,606, which exceeded the employer and member premiums of $42,769,443 paid to PacifiCare in FY 2008-2009 by $3,226,163, or 7.54 percent. Therefore, the close-out payment that HSS actually owes to PacifiCare is $3,226,163, or $823,837 less than the previously estimated PacifiCare close-out payment of $4,050,000. As noted above, the proposed FY 2010-2011 monthly premium rates already include a "flex-funded close down amount" of $1,100,000. Since the proposed FY 2010-2011 monthly premium rates already include $823,837 more than required to fully fund the PacifiCare close-out payment, HSS advises the monthly premium rates will be reduced by an offsetting $823,837 in FY 2011-2012[8].

RECOMMENDATION

Approve the proposed ordinance and resolution.

[8] According to Ms. Courtney, HSS is not amending the proposed monthly premium rates for FY 2010-2011 because (a) Mercer, the HSS consultant and actuary, would need to recalculate the rates and (b) the recalculated rates would need to be approved by the Health Service Board and the Board of Supervisors. Recalculating the monthly premium rates for FY 2010-2011 and resubmitting the rates for approval by the Health Service Board and the Board of Supervisors would delay HSS from establishing such rates in a timely manner for FY 2010-2011.

Harvey M. Rose

cc: Supervisor Avalos
Supervisor Mirkarimi
Supervisor Elsbernd
President Chiu
Supervisor Alioto-Pier
Supervisor Campos
Supervisor Chu
Supervisor Daly
Supervisor Dufty
Supervisor Mar
Supervisor Maxwell
Clerk of the Board
Cheryl Adams
Controller
Greg Wagner

10-County Survey

Exhibit 1
10-County Amount -- Change from 2009-10 to 2010-11

	2010-11	2009-10	Percent Change
1 Los Angeles	$457.56	$415.91	10.0%
2 San Diego	364.00	363.48	0.1%
3 Orange	383.75	372.44	3.0%
4 Riverside	488.44	491.27	-0.6%
5 San Bernardino	397.51	377.35	5.3%
6 Santa Clara	608.44	563.19	8.0%
7 Alameda	521.89	497.76	4.8%
8 Sacramento	561.35	516.78	8.6%
9 Contra Costa	495.15	470.02	5.3%
10 Fresno	450.43	425.43	5.9%
10-County Average	**$472.85**	**$449.37**	**5.2%**

City Health Plan – Full Monthly Premium Equivalent

Exhibit 2

City Health Plan -- Change in Full Monthly Premium Equivalent[1]

	2010-11					
	Before Claims Stabilization and Closedown Amount	Claims Stabilization[2]	Flex-Funded Closedown Amount	After Claims Stabilization and Closedown Amount	Dollar Change[3]	Percent Change[3]
Employee Only	$939.01	($13.97)	$1.62	$926.66	$118.38	14.6%
Employee + 1 Dependent	1,836.16	(27.32)	3.16	1,812.00	237.38	15.1%
Employee + 2 or more Dependents	2,576.67	(38.34)	4.43	2,542.76	332.10	15.0%
Retiree without Medicare	1,083.66	(16.13)	1.86	1,069.39	222.16	26.2%
Retiree and Spouse without Medicare	2,125.46	(31.63)	3.66	2,097.49	444.94	26.9%
Retiree with Medicare	372.79	(5.55)	0.64	367.88	41.85	12.8%
Retiree and Spouse with Medicare	711.05	(10.58)	1.22	701.69	84.64	13.7%

	2009-10			
	Before Claims Stabilization and Closedown Amount	Claims Stabilization[2]	Flex-Funded Closedown Amount	After Claims Stabilization and Closedown Amount
Employee Only	$815.86	($11.61)	$4.03	$808.28
Employee + 1 Dependent	1,589.40	(22.62)	7.84	1,574.62
Employee + 2 or more Dependents	2,231.40	(31.75)	11.01	2,210.66
Retiree without Medicare	855.18	(12.17)	4.22	847.23
Retiree and Spouse without Medicare	1,668.06	(23.74)	8.23	1,652.55
Retiree with Medicare	329.09	(4.68)	1.62	326.03
Retiree and Spouse with Medicare	622.85	(8.87)	3.07	617.05

[1] Rates shown include medical, pharmacy, vision, expense, claims stabilization, federal Medicare Part D subsidy, and the plan specific share of the PacifiCare Flex-funded plan's close down amount of $2.95 million and $1.1 million for the 2009-10 and 2010-11 plan years respectively.

[2] Reflects claims stabilization amount pursuant to the Board's Self-Funded Plan Funding Policy

[3] Change after Claims Stabilization and Flex Funded Closedown Amount.

HMOs – Full Monthly Premium Equivalent

Exhibit 4

HMOs -- Change in Full Monthly Premium Equivalent[1]

	2010-11			2009-10		
	Before Flex-Funded Closedown	Flex-Funded Closedown Amount	After Flex-Funded Closedown	After Flex-Funded Closedown	Dollar Change[2]	Percent Change[2]
Blue Shield						
Employee Only	$592.71	$1.02	$593.73	$532.89	$60.84	11.4%
Employee + 1 Dependent	1,184.42	2.04	1,186.46	1,064.76	121.70	11.4%
Employee + 2 or more Dependents	1,675.52	2.88	1,678.40	1,506.20	172.20	11.4%
Retiree without Medicare	1,316.08	2.26	1,318.34	1,182.64	135.70	11.5%
Retiree and Spouse without Medicare	1,907.79	3.28	1,911.07	1,714.51	196.56	11.5%
Retiree with Medicare	383.18	0.66	383.84	313.21	70.63	22.6%
Retiree and Spouse with Medicare	765.33	1.32	766.65	625.38	141.27	22.6%
Kaiser						
Employee Only	$480.86	$0.83	$481.69	$464.36	$17.33	3.7%
Employee + 1 Dependent	960.69	1.65	962.34	927.69	34.65	3.7%
Employee + 2 or more Dependents	1,358.95	2.34	1,361.29	1,312.24	49.05	3.7%
Retiree without Medicare	965.90	1.66	967.56	932.61	34.95	3.7%
Retiree and Spouse without Medicare	1,445.73	2.49	1,448.22	1,395.93	52.29	3.7%
Retiree with Medicare	346.39	0.60	346.99	350.55	(3.56)	-1.0%
Retiree and Spouse with Medicare	691.75	1.19	692.94	700.07	(7.13)	-1.0%

[1] Rates shown include HMO premium, vision, and expense components. Additionally, for 2009-10 and 2010-11, includes the plan specific share of the PacifiCare Flex-Funded plan's closedown amount of $2.95 million and $1.1 million respectively spread across all medical plans

[2] Change from the 2009-10 full monthly premium equivalent after application of Flex-Funded closedown

Vision Benefits

Exhibit 7
VSP Vision Plan -- Change in Full Monthly Cost

	2010-11[1]	2009-10[1]	Dollar Change	Percent Change
Employee Only	$3.57	$3.57	-	0.0%
Employee + 1 Dependent	7.15	7.15	-	0.0%
Employee + 2 or more Dependents	10.12	10.12	-	0.0%
Retiree without Medicare	3.57	3.57	-	0.0%
Retiree and Spouse without Medicare	7.15	7.15	-	0.0%
Retiree with Medicare	3.57	3.57	-	0.0%
Retiree and Spouse with Medicare	7.15	7.15	-	0.0%

[1] Vision plan rates are under a 2 year rate guarantee for the period July 1, 2009 through June 30, 2011.

Rhys Evans, FIA, ASA, MAAA

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January 29, 2010

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

Subject: 2010-11 Health 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 Health Service System (HSS) in regards to the recently completed rate and contribution setting process. This process was conducted under the direction of the Rates and Benefits Committee (the "Committee") of the Health Service Board. The rates, benefits, and contributions presented herein were approved by the full Health Service Board (the "HS Board") during their meeting on January 14, 2010.

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

- The insured premiums and administrative fees agreed to with HSS's vendors represent a fair price given the services provided and the risks insured.
- The premium equivalents set for the HSS self funded programs (City Health Plan and Active Dental benefits) represent our best estimate of future expenditures based on the information available at the time they were developed.
- Existing Trust Fund assets are expected to be sufficient to protect the HSS trust against adverse claims experience.

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 contributions provided by the ten most populous counties in California. This survey is conducted annually by HSS Staff. For the 2010-11 plan year, the survey determined that the average monthly contribution increased 5.2% from $449.37 to $472.85. Exhibit 1 of the attachment presents the individual responses from this survey.

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Rates, Contributions, and Benefits for the City Health Plan

The medical and pharmacy full monthly premium costs were set based on recent experience, with costs developed separately for actives, retirees without Medicare and retirees with Medicare based on group-specific experience. Additionally, we 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. These analyses were considered in conjunction with overall industry and normative data when determining the premium levels for the 2010-11 plan year (all analyses are on the www.myhss.org website as public documents).

The following plan design changes were presented and adopted by the HS Board for the City Health Plan, in order to comply with the Mental Health Parity Act of 2009 - premium equivalent rates were increased accordingly:

- The 25 visits per year limitation for combined network and out-of-network services for Mental Health and/or Substance Abuse outpatient therapy eliminated
- The 60 days per year limitation for two courses of treatment per lifetime for network and non-network benefits for inpatient chemical dependency rehabilitation eliminated
- The 30 medically certified days per year for non-Emergency inpatient detoxification eliminated
- The 30 days per year for network and non-network benefits for any combination of Mental Health Services and/or Substance Abuse inpatient hospitalization services eliminated

There are no other benefit changes for the 2010-11 plan year.

The United Healthcare ("UHC") administration fees were increased by 1.5% from the prior year. The HSS administration load remains unchanged.

Exhibit 2 of the attachment summarizes the change in full monthly premium equivalents for the City Health Plan. Included in the premium equivalent, pursuant to the HS Board's Self Funded Plans' Funding Policy, is the application of the claims stabilization amount and the PacifiCare Flex Funded plan's close out amount (see below).

Exhibit 3 of the attachment summarizes the change in employee and retiree contributions for the City Health Plan. These contributions were determined in accordance with the City Charter. The exhibit does not include any City contributions negotiated for specific groups in addition to the 10-County amount.

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Rates, Contributions, and Benefits for HMOs

Similar to the 2009-10 plan year, two HMOs are offered to HSS members: Blue Shield and Kaiser. The following summarizes the HMO renewal actions on a status quo basis:

Blue Shield

- Actives and retirees without Medicare: The initial proposal requested a 16.3% rate increase. This proposal was subsequently reduced to a 13.5% increase following negotiations resulting in an estimated $7.3 million premium savings for the 2010-11 plan year.
- Retirees with Medicare: For the 2009-10 plan year, Blue Shield introduced a Medicare Advantage Plan (MA-PD) alongside their Coordination of Benefits Plan (COB) option – the two plans were offered at the same rate. The initial proposal for the 2010-11 plan year presented two options for consideration
  1.) Coordination of Benefits (COB[1]) Plan only option: The initial proposal requested a 39.8% increase and was subsequently reduced to a 39.4% increase (2010-11 savings of $0.1 million).
  2.) Medicare Advantage Plan (MA-PD) / COB option[2]: The initial proposal requested a 30.1% increase and was subsequently reduced to a 24.5% increase (2010-11 savings of $1.0 million).

On January 14, 2010, the HS Board approved the MA-PD / COB option for retirees with Medicare. This option is expected to reduce premium costs by approximately $2.7 million for the 2010-11 plan year relative to the COB Plan only option.

---

[1] The COB option is based on the same network as the Blue Shield HMO for actives and non-Medicare retirees. Under COB, the plan is coordinated with Medicare and the member maintains rights to Medicare Parts A and B.

[2] Under the MA-PD/COB option, retirees who reside in the MA-PD service area will be enrolled in the MA-PD plan. Retirees outside the MA-PD service area will be enrolled in the COB plan. The MA-PD plan benefits are similar to the COB with a few exceptions due to the contract Blue Shield has in place with the Centers for Medicare & Medicaid Services: the emergency room copayment will be $50 for the MA-PD as compared to $100 for the COB, specialist visits require a referral under the MA-PD plan, and the MA-PD plan does not cover family planning or infertility benefits. The MA-PD is based on a narrower network of providers and facilities; enrolled members assign their Medicare Part A and B rights to the carrier and the carrier provides the benefits.

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Kaiser

- Actives and retirees without Medicare: The requested increase of 5.6% remained unchanged from their initial proposal.
- Retirees with Medicare: The requested increase of 6.3% remained unchanged from their initial proposal.

As part of the annual Rates and Benefits process, the Committee, HSS and Mercer review the continued appropriateness and competitiveness of the benefit design for the HMOs. The benchmark information (available on www.myhss.org website) reviewed suggested that certain sections of the plan design were outdated and did not reflect the impact from the continued high healthcare trends. In addition, changes were reviewed and approved due to the increased premium costs facing the membership and employers of the Health Service System. The HS Board was presented with many options and adopted the following benefit changes for the Blue Shield and Kaiser HMO plans:

- Blue Shield
  - $5 copayment increase (increase from $15 to $20)
  - Increase emergency room copayment from $50 to $100 (does not apply to Blue Shield MA-PD plan)
  - Introduce $15 copayment for preventive services which includes routine physicals, well baby care, gynecologic exams, and pre/post-natal care
- Kaiser
  - $5 copayment increase (increase from $10 to $15)
  - Increase emergency room copayment from $50 to $100 (does not apply to the plan available to Medicare retirees)

As a result of the changes, 2010-11 aggregate premiums were reduced by $4.4 million for the Blue Shield plans and $5.6 million for the Kaiser plans (total savings of $10 million).

Additionally, the following plan design changes were presented to the HS Board and approved for compliance with the Mental Health Parity Act of 2009:

- Blue Shield:
  - Change in mental health outpatient therapy copayments for both severe and non-severe visits to $20
  - Change in substance abuse outpatient therapy copayments to $20
  - Eliminate the 60 visit combined limitation for outpatient mental health/substance abuse

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- Eliminate the 30 days per year limitation for inpatient substance abuse therapy
- Mental health and substance abuse benefits will apply to the out of pocket maximum

- Kaiser:
  - Eliminate the 45 days per year limitation for inpatient mental health hospitalization
  - Eliminate the 20 visits per year limitation for outpatient therapy
  - Eliminate the 60 days per calendar year, not to exceed 120 days in any 5-year period limitation for substance abuse transitional residential recovery services
  - Eliminate the 30 days per calendar year rehabilitation limitation for substance abuse

Exhibit 4 of the attachment summarizes the full monthly HMO cost for the 2010-11 plan year. Included in the premium equivalent is the application of the PacifiCare Flex Funded plan's close out amount.

Contributions for HMO members were determined in accordance with the City Charter. Exhibits 5 and 6 of the attachment summarize changes in contributions for actives and retirees respectively. The exhibits do not include any City contributions negotiated for specific groups in addition to the 10-County amount.

Close out of PacifiCare Flex Funded Plan

Last year, the HS Board approved the process for the close out amount on the PacifiCare Flex Funded plan to be amortized over two plan years across all remaining medical plans (City Health Plan, Kaiser & Blue Shield). Each plan will be allocated a proportion of the close out liability based on their anticipated aggregate premium cost over the year of amortization. The two-year amortization was chosen as a balance between the pace at which the close out amount is recouped and the premium impact on the remaining plans.

The 2010-11 plan year is the second year of the two-year amortization of the Flex Funded close out liability. The amount to be collected over the 2010-11 plan year is estimated to be $1.1 million which is lower than the initial projection of $2.95 million. All medical plans' premiums or premium equivalent rates were increased accordingly by less than 0.2%. The amount collected over the 2009-10 plan year is estimated to be $2.95 million.

Mental Health Parity Act of 2009

On October 3, 2008, the Paul Wellstone and Pete Domenicic Mental Health Parity and

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Addiction Equity Act of 2009 ("MHSA Parity Act") became law. The MHSA Parity Act requires group health plans (fully insured and self-funded) that offer mental health (MH) or substance abuse (SA) benefits to provide those benefits on par with medical and surgical benefits. It also prohibits plans from imposing financial requirements or treatment limits on MH/SA that are more restrictive than the predominant financial or treatment limits on medical and surgical. The MHSA Parity Act applies to all City and County of San Francisco medical plans with the initial effective date of July 1, 2010. As part of the renewal process, we reviewed your plans for compliance with the act and adjustments have been made and reflected in the premium rates. Plan design changes are outlined above.

Rates and Benefits for the Vision Plan

Members enrolled in any medical plan offered by HSS also receive vision benefits through 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. The premiums remain unchanged from the 2009-10 rates and are under a rate guarantee through the end of the 2010-11 plan year. Exhibit 7 in the attachment summarizes the VSP vision plan costs.

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Rates, Contributions, and Benefits for Dental Plans

Three dental plans are offered to HSS members: Delta Dental PPO, Delta Care USA and UHC Dental (formerly known as Pacific Union). 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 the cost of dental benefits for employees, while retirees pay the full cost of their dental benefits.

The Delta Dental PPO plan for active employees is self-insured and administered by Delta Dental Plan 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 2009-10 fee and is guaranteed until the end of the 2012-13 plan year.

The Delta Dental PPO plan for retirees, Delta Care USA dental plans for employees and retirees, and UHC dental plans for employees and retirees are all fully insured. The rates for the Delta Dental PPO plan for retirees increased by 8.0%. The rates for the DeltaCare dental plan for employees and retirees increased by 6.9% and are guaranteed until the end of the 2012-13 plan year. The UHC dental plans for employees and retirees remain unchanged at the 2009-10 rates and are guaranteed until the end of the 2011-12 plan year.

Some minor plan enhancements (estimated 0.1% rate impact) were included in the Delta Dental PPO plan for retirees for 2010-11 including expanded IV sedation coverage, general anesthesia and IV sedation covered for selected endodontic procedures and periodontal surgeries, and frequency limitation to Panorex films. No plan design changes were applied to the other retiree dental plans. The dental plans available to employees will retain the current plan designs into the 2010-11 plan year.

The City's per-employee contribution for dental benefits is based on the average cost of coverage for all employees. The monthly contribution for 2010-11 will be $131.94 per employee per month, an increase of 13.2% over the $116.55 per employee per month contributed for the 2009-10 plan year. Included in this per employee rate, pursuant to the HS Board's Self Funded Plans' Funding Policy, is the application of the claims stabilization amount of approximately $1.3 million (equivalent to $3.64 per employee per month) of accrued deficit, which represents the shortfall of contributions received from employers compared to the costs incurred over the 2008-09 plan year.

Exhibit 8 in the attachment summarizes the changes in cost for active employee dental

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benefits.

City retirees who elect dental benefits have three plans to choose from. Benefits and rates differ from those for active employees. Exhibit 9 in the attachment summarizes the changes in cost for retirees' dental benefits.

Conclusion

Mercer would be pleased to answer any questions or provide clarification about the information included in this letter to any interested parties.

Sincerely,

R. W. Evans

Rhys Evans, FIA< ASA, MAAA

Copy:
Members of the Health Service Board
Catherine Dodd, Robin Courtney, Health Service System
Gerry Murphy, Gillian Printon, Jim Dell, Mercer

City Health Plan – Employee, Retiree, and Employer Contributions

Exhibit 3
City Health Plan -- Change in Monthly Employee, Retiree, and Employer Contributions

	Member Contributions				Employer[1] Contributions			
	2010-11	2009-10	Dollar Change	Percent Change	2010-11	2009-10	Dollar Change	Percent Change
Employee Only	$453.81	$358.91	$94.90	26.4%	$472.85	$449.37	$23.48	5.2%
Employee + 1 Dependent	1,339.15	1,125.25	213.90	19.0%	472.85	449.37	23.48	5.2%
Employee + 2 or more Dependents	2,069.91	1,761.29	308.62	17.5%	472.85	449.37	23.48	5.2%
Retiree without Medicare	226.90	179.45	47.45	26.4%	842.49	667.78	174.71	26.2%
Retiree and Spouse without Medicare	740.95	582.11	158.84	27.3%	1,356.54	1,070.44	286.10	26.7%
Retiree with Medicare	-	-	-	N/A	367.88	326.03	41.85	12.8%
Retiree and Spouse with Medicare	166.90	145.51	21.39	14.7%	534.79	471.54	63.25	13.4%

[1] Excludes additional negotiated contributions which apply to certain collectively bargained employees

HMOs – Employee and Employer Contributions

Exhibit 5
HMOs -- Change in Monthly Employee and Employer Contributions

	Member Contributions				Employer[1] Contributions			
	2010-11	2009-10	Dollar Change	Percent Change	2010-11	2009-10	Dollar Change	Percent Change
Blue Shield								
Employee Only	$120.88	$83.52	$37.36	44.7%	$472.85	$449.37	$23.48	5.2%
Employee + 1 Dependent	713.61	615.39	98.22	16.0%	472.85	449.37	23.48	5.2%
Employee + 2 or more Dependents	1,205.55	1,056.83	148.72	14.1%	472.85	449.37	23.48	5.2%
Kaiser								
Employee Only	$8.84	$14.99	($6.15)	-41.0%	$472.85	$449.37	$23.48	5.2%
Employee + 1 Dependent	489.49	478.32	11.17	2.3%	472.85	449.37	23.48	5.2%
Employee + 2 or more Dependents	888.44	862.87	25.57	3.0%	472.85	449.37	23.48	5.2%

[1] Excludes additional negotiated contributions which apply to certain collectively bargained employees

HMOs – Retiree and Employer Contributions

Exhibit 6
HMOs -- Change in Monthly Retiree and Employer Contributions

	Member Contributions				Employer Contributions			
	2010-11	2009-10	Dollar Change	Percent Change	2010-11	2009-10	Dollar Change	Percent Change
Blue Shield								
Retiree without Medicare	$60.44	$41.76	$18.68	44.7%	$1,257.90	$1,140.88	$117.02	10.3%
Retiree and Spouse without Medicare	356.80	307.69	49.11	16.0%	1,554.27	1,406.82	147.45	10.5%
Retiree with Medicare	-	-	-	N/A	383.84	313.21	70.63	22.6%
Retiree and Spouse with Medicare	191.40	156.08	35.32	22.6%	575.25	469.30	105.95	22.6%
Kaiser								
Retiree without Medicare	$4.42	$7.49	($3.07)	-41.0%	$963.14	$925.12	$38.02	4.1%
Retiree and Spouse without Medicare	244.75	239.15	5.60	2.3%	1,203.47	1,156.78	46.69	4.0%
Retiree with Medicare	-	-	-	N/A	346.99	350.55	(3.56)	-1.0%
Retiree and Spouse with Medicare	172.97	174.76	(1.79)	-1.0%	519.97	525.31	(5.34)	-1.0%

Dental Benefits – Active Employees

Exhibit 8
Dental Plans -- Change in Monthly Cost for Active Employees

	2010-11			2009-10				
	Before Claims Stabilization Amount	Claims Stabilization Amount[1]	After Claims Stabilization Amount	Before Claims Stabilization Amount	Claims Stabilization Amount[1]	After Claims Stabilization Amount	Dollar Change[2]	Percent Change[2]
Composite City Contribution[3]								
All Employees	$128.30	$3.64	$131.94	$116.27	$0.28	$116.55	$15.39	13.2%

[1] Total claims stabilization amount of approximately $1.3 million and $0.1 million applied to the 2010-11 and 2009-10 plan years respectively, pursuant to the Board's Self Funded Plans' Funding Policy

[2] Change from the 2009-10 composite rate, after the claims stabilization amount

[3] The composite rate reflects composites of the self-insured Delta Dental PPO and the two fully insured plans: Delta Care USA and UHC Dental (formally known as Pacific Union). The Delta Dental PPO Plan is self-insured by the City, with administrative fees unchanged from 2008-09 and guaranteed until the end of the 2012-13 plan year. The fully insured Delta Care USA plan premiums increased by 6.9% from 2009-10 and are guaranteed until the end of the 2012-13 plan year. The UHC Dental plan premiums remain unchanged from 2009-10 and are guaranteed until the end of the 2011-12 plan year.

Attachment V

Health Service System

CITY & COUNTY OF SAN FRANCISCO

MYHSS.ORG

MEMORANDUM

HAND DELIVERED

DATE: January 29, 2010

TO: Supervisor Sean Elsbernd
Board of Supervisors

FROM: Catherine Dodd, PhD, RN *Catherine Dodd*
Director, Health Service System

RE: Annual Certification of 10-County Amount Pursuant to Section A8.423 of Appendix A to the City Charter

---

Attached are the following documents relating to the above matter:

1. Certification to the Board of Supervisors, pursuant to Section A8.423 of Appendix A to the City Charter, of "the Average Contribution" as Determined by the Ten-County Survey Required under Such Charter Section, as adopted by the Health Service Board on January 14, 2010; and
2. Proposed Resolution Establishing Monthly Contribution Amount to Health Service Trust Fund.

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

Attachs.

cc: Members, Health Service Board (w/electronic attachs.) (via email)
Erik Rapoport (w/electronic attachs.) (via email)
Ben Rosenfield (w/electronic attachs.) (via email)
Rhys Evans (w/electronic attachs.) (via email)

1145 Market Street, 2ND Floor
San Francisco, CA 94103

Phone: (415) 554-1750
(800) 541-2266

Fax: (415) 554-1721

[2010 Certification of "the Average Contribution" Under Ten-County Survey]

CERTIFICATION TO THE BOARD OF SUPERVISORS, PURSUANT TO SECTION A8.423 OF APPENDIX A TO THE CITY CHARTER, OF "THE AVERAGE CONTRIBUTION" AS DETERMINED BY THE TEN-COUNTY SURVEY REQUIRED UNDER SUCH CHARTER SECTION.

WHEREAS, Pursuant to Section A8.423 of Appendix A to the City Charter, the Health Service Board (the "Board") is required to conduct a survey of the ten counties in the State of California, other than the City and County of San Francisco, having the largest populations to determine the average contribution made by each such county toward the providing of health care plans, exclusive of dental or optical care, for each employee of such county; and

WHEREAS, Pursuant to such Charter Section, the Board is required to certify to the Board of Supervisors "the average contribution" (as such term is defined in such Charter Section) as determined by such survey; and

WHEREAS, According to the State of California Department of Finance, the ten most populous counties in the State of California other than San Francisco (in descending order of population) are: Los Angeles, San Diego, Orange, Riverside, San Bernardino, Santa Clara, Alameda, Sacramento, Contra Costa and Fresno (collectively, the "Survey Counties"); and

WHEREAS, Under the survey of each of the Survey Counties which was completed on December 10, 2009 (a copy of which is attached as Exhibit A hereto and made a part hereof), the Board has determined that "the average contribution" is the sum of **four hundred seventy-two dollars and eighty five cents ($472.85)**; and

WHEREAS, The Board desires to certify "the average contribution" to the Board of Supervisors as required under Section A8.423 of Appendix A to the City Charter; now, therefore, be it

RESOLVED, That the Board hereby certifies to the Board of Supervisors that (a) the Board has conducted and completed as of January 14, 2010, a survey of the Survey Counties as required under Section A8.423 of Appendix A to the City Charter; and (b) "the average contribution" (as such term is defined in such Charter Section) determined under such survey is the sum of **four hundred seventy-two dollars and eighty five cents ($472.85)**; and, be it

FURTHER RESOLVED, That the Board hereby authorizes the Director of the Health Service System, to provide to or to execute and deliver to the Board of Supervisors, on behalf of the Board, such further information, certificates, assurances or other documents as the Board of Supervisors may require in connection with the current survey and certification required under Section A8.423 of Appendix A to the City Charter.

EXHIBIT A

Copy of Survey

The Process

The City Charter specifies that the City and County of San Francisco survey the 10 most populous counties in California and collect, for each county, the amount contributed by the employer for employee-only coverage under each of the county's medical plans. The survey includes contributions made for employees exclusive of any contributions made for employees' dependents.

We use the information gathered from the 10-county survey to compute an average increase in employer contributions for each county, and we then average the averages to arrive at the 10-county survey amount. The City is obligated by Charter to contribute the 10-county survey amount toward the cost of employees' medical benefits.

To help put the country contribution amounts into context, we also collect information on premium increases data on select plan design elements such as co-pays for office visits and emergency rooms, charges for hospital stays, prescriptions and deductibles.

The Results and Observations

The average monthly contribution of $472.85 for FY 2010-11 is 5.2 percent above the amount of $449.37 contributed by the employers' toward health care plans in FY 2009-10. This increase is consistent with the single digit increases we have experienced since 2006-2007.

The number of plan choices offered by the counties in the survey varies. At 18 offerings, Los Angeles provides members with the largest number of plan choices while San Diego, San Bernardino, and Santa Clara offer only three, the least number of choices.

In FY 2010-11, several Counties dropped and added plan offerings. San Diego dropped their PacifiCare POS and added a new PPO and HMO from Anthem-Blue Cross. Riverside dropped their Blue Shield PPO and added the Exclusive Care Select POS plan. Fresno County also replaced their Blue Shield vendor for their HMO, PPO, and HDPPO plans with Blue Cross

All counties except for Santa Clara County offer multiple plans from the same healthcare vendor. Additionally, Alameda County offers members a selection of plans from the same vendors based on $5, $10, and $15-copays.

While the purpose of the survey is to gather information on the employer contributions, we also collect premium data. In 2010-11, the average increase in premiums for the 10 counties surveyed was 8.8 percent. Fresno experienced the greatest increase at nearly 17 percent and Orange with a 3.2 percent increase had the lowest.

2010-2011 TEN COUNTY SURVEY

Average of Employer Contributions

Rank	County	2001-02	2002-03	2003-04	2004-05	2005-06	2006-07	2007-08	2008-09	2009-10	2010-11
1	Los Angeles	230.53	250.97	272.27	276.16	316.07	338.55	362.55	383.10	415.91	457.56
2	San Diego	168.26	179.96	207.95	262.38	267.86	363.48	305.87	327.00	363.48	364.00
3	Orange	287.37	390.87	383.50	395.83	374.13	380.63	387.92	338.64	372.44	383.75
4	Riverside	201.74	223.72	275.61	317.55	364.69	391.53	462.05	469.65	491.27	488.44
5	San Bernardino	208.84	223.35	242.53	298.45	333.57	299.72	313.73	368.67	377.35	397.51
6	Santa Clara	208.44	236.73	288.18	342.10	382.32	438.49	479.93	515.52	563.19	608.44
7	Alameda	191.53	218.30	265.38	276.28	316.40	342.11	398.35	440.58	497.76	521.89
8	Sacramento	227.92	259.84	308.98	315.25	363.89	422.13	480.54	480.76	516.78	561.35
9	Contra Costa	191.31	209.84	267.55	299.35	336.62	366.77	407.86	438.47	470.02	495.15
10	Fresno	223.32	273.35	300.16	345.67	399.71	390.06	432.64	425.58	425.43	450.43
	Average	**213.93**	**246.69**	**281.21**	**312.90**	**345.53**	**373.35**	**403.14**	**418.80**	**449.37**	**472.85**

Increase Over Prior Year

Rank	County	2001-02	2002-03	2003-04	2004-05	2005-06	2006-07	2007-08	2008-09	2009-10	2010-11
1	Los Angeles	6.2%	8.9%	8.5%	1.4%	14.5%	7.1%	7.1%	5.7%	8.6%	10.0%
2	San Diego	9.4%	7.0%	15.6%	26.2%	2.1%	35.7%	-15.8%	6.9%	11.2%	0.1%
3	Orange	12.6%	36.0%	-1.9%	3.2%	-5.5%	1.7%	1.9%	-12.7%	10.0%	3.0%
4	Riverside	9.8%	10.9%	23.2%	15.2%	14.8%	7.4%	18.0%	1.6%	4.6%	-0.6%
5	San Bernardino	18.1%	6.9%	8.6%	23.1%	11.8%	-10.1%	4.7%	17.5%	2.4%	5.3%
6	Santa Clara	9.5%	13.6%	21.7%	18.7%	11.8%	14.7%	9.5%	7.4%	9.2%	8.0%
7	Alameda	2.5%	14.0%	21.6%	4.1%	14.5%	8.1%	16.4%	10.6%	13.0%	4.8%
8	Sacramento	15.0%	14.0%	18.9%	2.0%	15.4%	16.0%	13.8%	0.0%	7.5%	8.6%
9	Contra Costa	9.6%	9.7%	27.5%	11.9%	12.5%	9.0%	11.2%	7.5%	7.2%	5.3%
10	Fresno	20.3%	22.4%	9.8%	15.2%	15.6%	-2.4%	10.9%	-1.6%	0.0%	5.9%
	Average	**11.3%**	**15.3%**	**14.0%**	**11.3%**	**10.4%**	**8.1%**	**8.0%**	**3.9%**	**7.3%**	**5.2%**

2010-2011 TEN COUNTY SURVEY

1. Los Angeles County						Population 10,393,185
Medical Plans	2009-10 Premium	2010-11 Premium	% +/-	2009-10 County Contribution	2010-11 County Contribution	% +/-
Kaiser Choices HMO - County Sponsored	448.77	490.71	9.3%	448.77	490.71	9.3%
CIGNA Choices HMO - County Sponsored	334.14	408.30	22.2%	334.14	408.30	22.2%
CIGNA Choices POS - County Sponsored	599.57	732.63	22.2%	531.07	573.56	8.0%
Blue Cross Prudent Buyer Basic- ALADS	601.37	646.33	7.5%	531.07	573.56	8.0%
Blue Cross CaliforniaCare Basic- ALADS	392.77	418.41	6.5%	392.77	418.41	6.5%
Blue Cross Prudent Buyer Premier- ALADS	689.89	741.71	7.5%	531.07	573.56	8.0%
Blue Cross CaliforniaCare Premier - ALADS	481.29	513.79	6.8%	481.29	513.79	6.8%
Blue Shield Classic CAPE	564.90	607.00	7.5%	531.07	573.56	8.0%
Blue Shield Lite CAPE	335.72	363.00	8.1%	335.72	363.00	8.1%
Local 1014 Plan - Fire Fighters	496.00	501.00	1.0%	496.00	501.00	1.0%
Kaiser Options - SEIU	425.94	466.86	9.6%	425.94	466.86	9.6%
Kaiser HMO - Unrepresented	248.00	288.00	16.1%	248.00	288.00	16.1%
Blue Cross CaliforniaCare HMO - Unrepresented	248.00	288.00	16.1%	248.00	288.00	16.1%
Blue Cross Plus POS - Unrepresented	375.00	435.00	16.0%	375.00	435.00	16.0%
Blue Cross Catastrophic - Unrepresented	192.00	223.00	16.1%	192.00	223.00	16.1%
Blue Cross Prudent Buyer PPO - Unrepresented	478.00	554.00	15.9%	478.00	554.00	15.9%
PacifiCare Options HMO - SEIU	375.43	418.17	11.4%	375.43	418.17	11.4%
PacifiCare Options PPO - SEIU	1,056.27	1,180.83	11.8%	531.07	573.56	8.0%
Average	463.50	515.37	11.2%	415.91	457.56	10.0%

2010-2011 TEN COUNTY SURVEY

1. Los Angeles County: Medical Plan Design Summary

Blue Shield Lite	HMO	PO S- In	POS - Out
Deductible	None	$500/$1000	$500/$1000
Physicians Services	$10 Copay	$25 Copay	60/40 After Ded
Emergency Room	$50 Copay	$50 Copay	$50 Copay
Rx	$5/$15/$30	$10/$15/$30	Not Covered
Hospital	No Charge	80/20 After Ded	60/40 After Ded
Blue Shield Classic	**HMO**	**PO S- In**	**POS - Out**
Deductible	None	$300/$600	$300/$600
Physicians Services	$10 Copay	$20 Copay	60/40 After Ded
Emergency Room	$50 Copay	$50 Copay	$50 Copay
Rx	$5/$15/$30	$10/$15/$30	Not Covered
Hospital	No Charge	90/10 After Ded	60/40 After Ded
PacifiCare	**HMO**	**PPO - In**	**PPO - Out**
Deductible	None	$300/$1500	$1500/$3000
Physicians Services	$10 Copay	80/20	50/50 After Ded
Emergency Room	$50 Copay	80/20 After Ded	50/50 After Ded
Rx	$5/$20	$5/$20/$35	Not Covered
Hospital	No Charge	80/20 After Ded	50/50 After Ded
Kaiser	**Options**	**Choices**	**Unrep**
Deductible	None	None	None
Physicians Services	$10 Copay	$10 Copay	$15 Copay
Emergency Room	$50 Copay	$50 Copay	$50 Copay
Rx	$5/$20	$5/$20	$10/$20
Hospital	No Charge	No Charge	No Charge
Cigna	**HMO**	**POS-In**	**POS-Out**
Deductible	None	None	$500/$1000
Physicians Services	$10 Copay	$10 Copay	60/40 After Ded
Emergency Room	$50 Copay	$50 Copay	60/40 After Ded
Rx	$5/$20	$5/$20	60/40 After Ded
Hospital	No Charge	$50 Copay/Day	60/40 After Ded + $1000/Admit

2010-2011 TEN COUNTY SURVEY

1. Los Angeles County: Medical Plan Design Summary

Blue Cross California Care Hmo	ALADS	UNREP		
Deductible	None	None		
Physicians Services	$5 Copay	$15 Copay		
Emergency Room	$25 Copay	$50 Copay		
Rx	$5/$10	$10/$20		
Hospital	No Charge	No Charge		
Blue Cross Plus (Unrep)	**HMO**	**POS - In**	**POS - Out**	
Deductible	None	None	$400/$800	
Physicians Services	$10 Copay	$20 Copay	60/40 After Ded	
Emergency Room	$50 Copay	$50 Copay	$50 Copay	
Rx	$10/$20	$10/$20	$10/$20	
Hospital	No Charge	80/20	70/30 + $500/Admit	
Local 1014 Plan	**HMO**			
Deductible	$200/$600			
Physicians Services	90/10 After Ded			
Emergency Room	$50 Copay			
Rx	$10/$20/$30+			
Hospital	90/10 After Ded			
Blue Cross	**Catastrophic**			
Deductible	$2000/$4000			
Physicians Services	75/25 After Ded			
Emergency Room	$100 Copay			
Rx	$200 Ded Then 75/25			
Hospital	75/25 After Ded + $500/Admit			
Blue Cross Prudent Buyer PPO	**ALADS - In**	**ALADS - Out**	**UNREP - In**	**UNREP - Out**
Deductible	200/600	$200/$600	$150/$450	$400/$800
Physicians Services	90/10 After Ded	70/30 After Ded	$15 Copay	70% After Ded
Emergency Room	$50 Copay	70/30 After Ded	$50 Copay Then 90/10	$50 Copay Then 90/10
Rx	$5/$0	$5/$10+	$10/$20	$10/$20
Hospital	90/10 No Charge After Ded	70/30 After Ded	90/10 After Ded	70/30 After Ded + $500/Admit

2010-2011 TEN COUNTY SURVEY

2. San Diego County

Population 3,173,407

Medical Plans	2009-10 Premium	2010-11 Premium	% +/-	2009-10 County Contribution	2010-11 County Contribution	% +/-
Kaiser HMO	350.42	371.80	6.1%	350.42	364.00	7.3%
PacifiCare POS	425.26	0	-100.0%	376.54	0	6.5%
Anthem - Blue Cross PPO	0	478.12	-	0	364.00	-
Anthem - Blue Cross HMO	0	437.08	-	0	364.00	-
Average	387.84	429.00	10.6%	363.48	364.00	0.1%

2. San Diego County: Medical Plan Design Summary

Kaiser	HMO		
Deductible	None		
Physicians Services	$15 Copay		
Emergency Room	$35 Copay		
Rx	$10/$20		
Hospital	No Charge		
Anthem Blue Cross	**PPO- In**	**PPO - Out**	
Deductible	$300/$600	$600/$1200	
Physicians Services	$20	$40	
Emergency Room	$75	80% After Ded	
Rx	$10/$20	$10/$20	
Hospital	$150	$300	
Anthem Blue Cross	**HMO**		
Deductible	None		
Physicians Services	$20		
Emergency Room	$100		
Rx	$10/$20		
Hospital	$150		

2010-2011 TEN COUNTY SURVEY

3. Orange County — Population 3,139,017

Medical Plans	2009-10 Premium	2010-11 Premium	% +/-	2009-10 County Contribution	2010-11 County Contribution	% +/-
Premiere Wellwise PPO	520.09	526.85	1.3%	497.21	503.64	1.3%
Premiere Sharewell PPO	208.04	210.74	1.3%	277.06	279.77	1.0%
CIGNA HMO	404.99	427.35	5.5%	384.75	405.77	5.5%
Kaiser HMO	348.13	364.03	4.6%	330.73	345.83	4.6%
Average	370.31	382.24	3.2%	372.44	383.75	3.0%

2010-2011 TEN COUNTY SURVEY

3. Orange County: Medical Plan Design Summary

Wellwise	PPO - In	PPO - Out	
Deductible	$300/$600	$500/$1000	
Physicians Services	90/10	70/30	
Emergency Room	90/10	70/30	
Rx	20%/25%/30%	20%/25%/30%	
Hospital	90/10	70/30	
Sharewell	**PPO - In**	**PPO - Out**	
Deductible	$5000 Per Family	$5000 Per Family	
Physicians Services	90/10	80/20	
Emergency Room	90/10	80/20	
Rx	20%	20%	
Hospital	90/10	80/20	
Cigna	**HMO**		
Deductible	None		
Physicians Services	$15 Copay		
Emergency Room	$50 Copay		
Rx	$10/$20/$40		
Hospital	$100 Per Admit		
Kaiser	**HMO**		
Deductible	None		
Physicians Services	$15 Copay		
Emergency Room	$50 Copay		
Rx	$10/$20		
Hospital	$100 Per Admit		

4. Riverside County

Population 2,107,653

Medical Plans	2009-10 Premium	2010-11 Premium	% +/-	2009-10 County Contribution	2010-11 County Contribution	% +/-
Blue Shield HMO	461.70	487.30	5.5%	461.70	487.30	5.5%
Blue Shield PPO	887.80	-	-	751.28	-	-
Kaiser HMO	454.00	469.00	3.3%	454.00	469.00	3.3%
Exclusive Care EPO	338.14	354.86	4.9%	338.14	354.86	4.9%
Exclusive Care Select POS[1]	-	1,020.98	-	-	651.28	-
Blue Shield HMO - PERS	471.18	485.30	3.0%	471.18	485.30	3.0%
Kaiser HMO - PERS	425.11	455.00	7.0%	425.11	455.00	7.0%
PERSCare	712.71	806.90	13.2%	712.71	651.28	-8.6%
PERS Choice	458.59	472.84	3.1%	458.59	472.84	3.1%
PORAC - PERS	484.00	484.00	0.0%	484.00	484.00	0.0%
Blue Shield HPN	416.49	420.60	1.0%	416.49	420.60	1.0%
PERS Select	430.72	441.42	2.5%	430.72	441.42	2.5%
Average	503.68	536.20	6.5%	491.27	488.44	-0.6%

[1] New Plan in 2010-11 to replace the Blue Shield PPO which was discontinued.

4. Riverside County: Medical Plan Design Summary

Blue Shield	HMO		
Deductible	None		
Physicians Services	$15 Copay		
Emergency Room	$50 Copay		
Rx	$10/$25/$50		
Hospital	No Charge		
Kaiser	**HMO**		
Deductible	None		
Physicians Services	$15 Copay		
Emergency Room	$50 Copay		
Rx	$10/$25		
Hospital	No Charge		
Exclusive Care	**EPO**		
Deductible	None		
Physicians Services	$5 Copay		
Emergency Room	$50 Copay		
Rx	$5/$15/$25		
Hospital	No Charge		
Exclusive Care Select POS	**Tier 1**	**Tier 2 - Natl Network**	**Tier 3 - Out**
Deductible	$250/$750	$500/$1500	$1,000/$3,000
Physicians Services	$10 Copay	$25 Copay	60% Aft Ded
Emergency Room	90% After $50 Copay	80% After $100 Copay	80% Aft Ded; $100 Copay
Rx	$15/$25/$40	$15/$25/$40	$15/$25/$40
Hospital	90/10	80/10	60/40

2010-2011 TEN COUNTY SURVEY

5. San Bernardino County — Population 2,060,950

Medical Plans	2009-10 Premium	2010-11 Premium	% +/-	2009-10 County Contribution	2010-11 County Contribution	% +/-
Kaiser HMO	385.80	421.27	9.2%	385.80	411.67	6.7%
Health Net Elect Open Access HMO	334.60	369.20	10.3%	334.60	369.20	10.3%
Health Net PPO	722.87	746.07	3.2%	411.67	411.67	0.0%
Average	481.09	512.18	6.5%	377.35	397.51	5.3%

5. San Bernardino County: Medical Plan Design Summary

Kaiser	HMO		
Deductible	None		
Physicians Services	$10 Copay		
Emergency Room	$50 Copay		
Hospital	No Charge		
Rx	$10/$15		
Health Net Open Access	**Tier 1 - HMO**	**Tier 2 - PPO**	
Deductible	None	None	
Physicians Services	$10 Copay	$30 Copay	
Emergency Room	$50 Copay	Not Covered	
Hospital	No Charge	Not Covered	
Rx	$5/$10/$25	$5/$10/$25	
Health Net	**PPO - In**	**PPO - Out**	
Deductible	$250/$750	$250/$750	
Physicians Services	80/20	70/30	
Emergency Room	$50 Copay	$50 Copay	
Hospital	80/20	70/30	
Rx	No Charge	80/20 After Ded	
Hospital			

2010-2011 TEN COUNTY SURVEY

6. Santa Clara County — Population 1,857,621

Medical Plans	2009-10 Premium	2010-11 Premium	% +/-	2009-10 County Contribution	2010-11 County Contribution	% +/-
Kaiser HMO	490.27	523.06	6.7%	490.27	523.06	6.7%
Valley Health HMO	490.27	523.06	6.7%	490.27	523.06	6.7%
Health Net POS	709.02	779.22	9.9%	709.02	779.22	9.9%
Average	563.19	608.44	8.0%	563.19	608.44	8.0%

6. Santa Clara County: Medical Plan Design Summary

Kaiser	HMO		
Deductible	None		
Physicians Services	$5 Copay		
Emergency Room	$5 Copay		
Rx	$5		
Hospital	No Charge		
Valley Health	**HMO**		
Deductible	None		
Physicians Services	No Charge		
Emergency Room	No Charge		
Rx	No Charge		
Hospital	No Charge		
Health Net POS	**HMO**	**PPO - In**	**PPO - Out**
Deductible	None	None	$200/PMPY
Physicians Services	$5 Copay	$10 Copay	70/30
Emergency Room	$35 Copay	90/10	70/30
Rx	$5/$10/$20	$5/$10/$20	$5/$10/$20
Hospital	No Charge	90/10	70/30

7. Alameda County

Population 1,556,657

Medical Plans	2009-10 Premium	2010-11 Premium	% +/-	2009-10 County Contribution	2010-11 County Contribution	% +/-
Pacificare HMO ($5)	594.48	683.82	15.0%	522.48	550.34	15.0%
Kaiser HMO ($5)	522.48	550.34	5.3%	522.48	550.34	5.3%
Blue Cross HMO ($5)	668.98	706.44	5.6%	522.48	550.34	5.6%
Pacificare PPO ($5)	1,445.16	1,609.92	11.4%	522.48	550.34	11.4%
Pacificare HMO ($15)	559.56	623.42	11.4%	492.72	503.56	11.4%
Kaiser HMO ($15)	492.72	503.56	2.2%	492.72	503.56	2.2%
Blue Cross HMO ($15)	629.76	643.94	2.3%	492.72	503.56	2.3%
Pacificare PPO ($15)	1,445.16	1,609.92	11.4%	492.72	503.56	11.4%
Pacificare HMO ($15)	541.96	623.42	15.0%	478.08	561.08	15.0%
Kaiser HMO ($15)	478.08	501.56	4.9%	478.08	453.20	4.9%
Blue Cross HMO ($15)	609.78	643.94	5.6%	478.08	579.56	5.6%
Pacificare PPO ($15)	1,445.16	1,609.92	11.4%	478.08	453.20	11.4%
Average	786.11	859.18	9.3%	497.76	521.89	4.8%

7. Alameda County: Medical Plan Design Summary

PacifiCare	HMO - $5	HMO - $10	HMO - $15
Deductible	None	None	None
Physicians Services	$5 Copay	$10 Copay	$15 Copay
Emergency Room	$35 Copay	$35 Copay	$50 Copay
Rx	$5/$10/$35	$10/$20/$35	$10/$25/$35
Hospital	No Charge	No Charge	No Charge
Kaiser	**HMO - $5**	**HMO - $10**	**HMO - $15**
Deductible	None	None	None
Physicians Services	$5 Copay	$10 Copay	$15 Copay
Emergency Room	$5 Copay	$25 Copay	$50 Copay
Rx	$5/$5	$10/$10	$15/$15
Hospital	No Charge	No Charge	No Charge
Blue Cross	**HMO - $5**	**HMO - $10**	**HMO - $15**
Deductible	None	None	None
Physicians Services	$5 Copay	$10 Copay	$15 Copay
Emergency Room	$35 Copay	$35 Copay	$50 Copay
Rx	$5/$10/$35	$10/$20/$35	$10/$25/$35
Hospital	No Charge	No Charge	No Charge

8. Sacramento County

Population 1,433,187

Medical Plans	2009-10 Premium	2010-11 Premium	% +/-	2009-10 County Contribution	2010-11 County Contribution	% +/-
Blue Shield HMO 15	686.96	744.12	8.3%	686.96	744.12	8.3%
Health Net HMO 15	533.08	560.04	5.1%	533.08	560.04	5.1%
Kaiser HMO 15	459.44	498.90	8.6%	459.44	498.90	8.6%
Blue Shield HDHP PPO	542.36	610.62	12.6%	542.36	610.62	12.6%
Kaiser HDHP HMO	362.08	393.08	8.6%	362.08	393.08	8.6%
Average	516.78	561.35	8.6%	516.78	561.35	8.6%

8. Sacramento County: Medical Plan Design Summary

Blue Shield	HMO	HDHP - PPO In	HDHP - PPO Out
Deductible	None	$1500/$3000	$1500/$3000
Physicians Services	$15 Copay	80/20	60/40
Emergency Room	$50 Copay	80/20	80/20
Rx	$10/$20/$35	$10/$25/$40	$10/$25/$40 + 25%
Hospital	No Charge	80/20	60/40
HealthNet	**HMO**		
Deductible	None		
Physicians Services	$15 Copay		
Emergency Room	$35 Copay		
Rx	$10/$20/$35		
Hospital	No Charge		
Kaiser	**HMO**	**HDHP - HMO**	
Deductible	None	$1500/$3000	
Physicians Services	$15 Copay	No Charge After Ded	
Emergency Room	$35 Copay	No Charge After Ded	
Rx	$10/$20	No Charge After Ded	
Hospital	No Charge	No Charge After Ded	

2010-2011 TEN COUNTY SURVEY

9. Contra Costa County

Population 1,060,435

Medical Plans	2009-10 Premium	2010-11 Premium	% +/-	2009-10 County Contribution	2010-11 County Contribution	% +/-
CCHP Plan A	526.23	536.75	2.0%	515.71	499.18	-3.2%
CCHP Plan B	580.54	592.15	2.0%	522.49	515.17	-1.4%
Health Net HMO	668.66	781.71	16.9%	534.93	611.22	14.3%
Health Net EPO	668.66	781.71	16.9%	534.93	611.22	14.3%
Helath Net PPO	883.09	946.32	7.2%	512.63	544.25	6.2%
Kaiser HMO	527.28	572.41	8.6%	421.82	444.39	5.4%
Blue Shield HMO - PERS	560.57	577.33	3.0%	442.22	463.33	4.8%
CCHP Plan A Alternate - PERS	621.51	633.94	2.0%	442.22	463.33	4.8%
Kaiser HMO - PERS	508.30	532.56	4.8%	442.22	463.33	4.8%
PERS Care	749.83	868.17	15.8%	442.22	463.33	4.8%
PERS Choice	482.48	508.74	5.4%	442.22	463.33	4.8%
PORAC - PERS	484.00	484.00	0.0%	442.22	463.33	4.8%
PERS Select	453.16	474.93	4.8%	442.22	463.33	4.8%
Blue Shield HMO NetValue - PERS	495.50	500.35	1.0%	442.22	463.33	4.8%
Average	586.42	627.93	7.1%	470.02	495.15	5.3%

9. Contra Costa County: Medical Plan Design Summary

CCHP	Plan A	Plan B	
Deductible	None	None	
Physicians Services	No Charge	$5 Copay	
Emergency Room	No Charge	$20 Copay	
Rx	No Charge	$3 Per Rx	
Hospital	No Charge	No Charge	
Health Net	**HMO**	**EPO**	
Deductible	None	None	
Physicians Services	$10 Copay	$10 Copay	
Emergency Room	$25 Copay	$25 Copay	
Rx	$10/$20/$35	$10/$20/$35	
Hospital	No Charge	No Charge	
Health Net	**PPO - In**	**PPO - Out**	
Deductible	$250/$750	$250/$750	
Physicians Services	90/10	70/30	
Emergency Room	90/10 Aft $50 Copay	90/10 Aft $50 Copay	
Rx	$5/$5	$5/$5	
Hospital	90/10	70/30	
Kaiser	**HMO**		
Deductible	None		
Physicians Services	$10 Copay		
Emergency Room	$10 Copay		
Rx	$10/$20		
Hospital	No Charge		

10. Fresno County

Population 942,298

Medical Plans	2009-10 Premium	2010-11 Premium	% +/-	2009-10 County Contribution	2010-11 County Contribution	% +/-
Blue Shield HMO	450.30	-	-	-	-	-
Kaiser $15 HMO	601.23	719.92	19.7%	450.80	450.80	0.0%
Blue Shield PPO	635.53	-	-	-	-	-
Blue Shield HDPPO	349.83	-	-	-	-	-
Blue Cross HMO[1]	-	494.00	-	450.30	450.30	0.0%
Blue Cross PPO[1]	-	742.04	-	450.80	450.30	-0.1%
Blue Cross HDPPO[1]	-	423.65	-	349.83	450.30	28.7%
Average	509.22	594.90	16.8%	425.43	450.43	5.9%

[1]Plans added in 2010-2011 to replace Blue Shield.

10. Fresno County: Medical Plan Design Summary

Kaiser	HMO		
Deductible	None		
Physicians Services	$10 Copay		
Emergency Room	$50 Copay		
Rx	$10/$15/$30		
Hospital	No Charge		
Blue Cross - Anthem	**HMO**	**PPO - In**	
Deductible	None	$250	
Physicians Services	$15 Copay	$20 Copay	
Emergency Room	$100 Per Admit	$100 Per Admit	
Rx	$10/$20/$35	$10/$20/$35	
Hospital	No Charge	No Charge	
Blue Cross - Anthem	**HDPPO - In**	**HDPPO - Out**	
Deductible	$3,000/$6,000	$3,000/$6,000	
Physicians Services	No Charge	50% After Ded	
Emergency Room	No Charge	No Charge After Ded	
Rx	No Charge	50/50	
Hospital	No Charge	No Charge After Ded	

CERTIFICATION

I hereby certify that I perform the functions of the Secretary of the Health Service Board, and that the above Resolution was duly adopted and approved by the Health Service Board at a properly noticed meeting on January 14, 2010.

Laini K. Scott

Laini K. Scott