File No. 160747 Committee Item No. 1
Board Item No. 6

COMMITTEE/BOARD OF SUPERVISORS

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Committee: Budget & Finance Sub-Committee **Date** July 20, 2016

Board of Supervisors Meeting **Date** August 2, 2016

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Completed by: Linda Wong **Date** July 15, 2016
Completed by: Linda Wong **Date** July 21, 2016

FILE NO. 160747 ORDINANCE).

[Administrative Code - Health Service System Plans and Contribution Rates for Calendar Year 2017]

Ordinance approving Health Service System plans and contribution rates for calendar year 2017, and amending the Administrative Code to remove those rates from the Code.

NOTE: **Unchanged Code text and uncodified text** are in plain Arial font.
Additions to Codes are in *single-underline italics Times New Roman font*.
Deletions to Codes are in ~~*strikethrough italics Times New Roman font*~~.
Board amendment additions are in double-underlined Arial font.
Board amendment deletions are in ~~strikethrough Arial font~~.
Asterisks (* * * *) indicate the omission of unchanged Code subsections or parts of tables.

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

Section 1. Background and Findings.

(a) Under Charter Section A8.423, the Health Service Board (HSB) 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. The HSB is then required to certify to the Board of Supervisors "the average contribution" as determined by the survey.

(b) According to the 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").

(c) On March 10, 2016, based on the Health Service System's survey of each of the Survey Counties, a copy of which is on file with the Clerk of the Board of Supervisors in Board

File No. 160747, the HSB determined that "the average contribution" made by the counties surveyed for the 2017 calendar plan year is $604.84.

(d) At its meetings of May 12, June 9 and June 21, 2016, the HSB adopted health insurance plans and contribution rates for Health Service System plans to become effective on January 1, 2017, for the calendar plan year January 1, 2017 through December 31, 2017. Said plans and contribution rates are on file with Clerk of the Board of Supervisors in Board File No. 160747, and are incorporated herein by reference.

Section 2. The Board of Supervisors hereby approves the health insurance plans and contribution rates adopted by the HSB on May 12, June 9 and June 21, 2016, as referenced in subsection (d) of Section 1 of this ordinance. The Health Insurance Plans are expected to exceed 10 million dollars in expenditures, and Charter Section 9.118(b) requires Board of Supervisors Approval, which is hereby granted.

Section 3. As referenced in subsection (c) of Section 1 of this ordinance, "the average contribution" under Charter Section A8.423, which shall constitute the monthly amount contributed by participating employers to the Health Service Trust Fund for the calendar plan year January 1, 2017 through December 31, 2017, as required under Charter Section A8.428(b)(2), is $604.84.

Section 4. The Administrative Code is hereby amended by deleting Section 16.703 in its entirety, as follows:

~~*SEC. 16.703. HEALTH SERVICE SYSTEM; PLAN AND CONTRIBUTION RATES.*~~

~~*Changes in contribution rates adopted by the Health Service Board for the plans of the Health Service System, to become effective on January 1, 2016 for the calendar plan year January 1, 2016 through December 31, 2016, approved by the Health Service Board in actions taken by it on June 11, 2015, which plans and contribution rates are on file with the Clerk of the Board of Supervisors, are hereby approved.*~~

Section 5. Effective Date. This ordinance shall become effective 30 days after enactment. Enactment occurs when the Mayor signs the ordinance, the Mayor returns the ordinance unsigned or does not sign the ordinance within ten days of receiving it, or the Board of Supervisors overrides the Mayor's veto of the ordinance

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

By: Erik A Rapoport
ERIK A. RAPOPORT
Deputy City Attorney

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FILE NO. 160747

LEGISLATIVE DIGEST

[Administrative Code - Health Service System Plans and Contribution Rates for Calendar Year 2017]

Ordinance approving Health Service System plans and contribution rates for calendar year 2017, and amending the Administrative Code to remove those rates from the Code.

Existing Law

The San Francisco Board of Supervisors (Board) approves rates and benefits for San Francisco Health Service System (HSS) members by amending Administrative Code Section 16.703.

Amendments to Current Law

Administrative Code Section 16.703 will be deleted, and the Board will approve HSS member rates and benefits under an uncodified ordinance.

Background Information

In prior years, the Board approved rates and benefits by amending Administrative Code Section 16.703, and approved by resolution the employer's "average contribution" toward HSS member health insurance premiums, as required under Charter Section A8.423. The "average contribution" is the average contribution made by the ten counties in California with the largest populations toward the providing of health care plans, exclusive of dental or optical care, for each employee of such county. In order to simplify the process, the Board will now approve HSS member rates and benefits, and the employer's "average contribution" toward member health insurance premiums, through a single uncodified ordinance.

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Item 1 File 16-0747	Department: Health Service System (HSS)

EXECUTIVE SUMMARY

Legislative Objectives

- The proposed ordinance would approve the Health Service System's health, vision, and dental plans and contribution rates for calendar year 2017 and amend the City's Administrative Code Section 16.703 to remove rates from the Code.

Key Points

- In accordance with the City's Charter, the Health Service Board is required to conduct a survey of the ten most populous California counties each year to determine the average of the health premium contributions made by these counties. Based on this survey, the average 2017 contribution is $604.84 per member per month, which is $25.60 or 4.4 percent more than the 10-county average monthly contribution of $579.24 in 2016.
- Effective January 1, 2015, collective bargaining agreements eliminated the 10-county average survey as the method for calculating monthly premiums for active employees. Instead, the City and most unions elected to use a percentage-based employee premium contribution models. The 10-county survey is still used to calculate retiree premiums.
- The total 2017 monthly health premiums for active employees-only coverage is proposed to be (a) $802.40 for the City Plan, a 6.04 percent increase from 2016, (b) $582.54 for Kaiser, a 5.5 percent increase from 2016, and (c) $752.25 for Blue Shield, a 4.26 percent increase from 2016.

Fiscal Impacts

- The total estimated City, employee, and retiree costs for health, vision, and dental plans, as well as long-term disability and life insurance plans, is $653,375,067 in 2017, which is a $29,862,936 or 4.79 percent increase from $623,512,131 in 2016.
- Regarding just the City's estimated costs, the total for the health, vision, and dental plans, and long-term disability and life insurance plans in 2017 is $581,013,572, which is a $24,282,943, or 4.36 percent increase from $556,730,628 in 2016.
- The balance of $72,361,495 ($653,375,067 total 2017 costs less $581,013,572 City 2017 costs) is paid by employees and retirees.
- Health premium contributions in 2017 are based on cost-sharing agreements that were negotiated between the City and various labor unions which became effective on January 1, 2015. Under these cost-sharing agreements, with the exception of Kaiser, the City pays more than under the 10-county survey average amount of $604.84.

Recommendation

- Approve the proposed ordinance.

MANDATE STATEMENT

City Charter Section A8.423 states that the Health Service Board is required to conduct a survey of the ten most populous California counties, excluding San Francisco, to determine the average contribution made by each county toward health plan premiums for employees, excluding dental or optical plan premiums. The Health Service Board is then required to certify to the Board of Supervisors the average contribution as determined by this survey. City Charter Section A8.428 also requires the City to contribute to the Health Service System Trust Fund to pay the costs of health plan premiums.

BACKGROUND

The Health Service Board oversees the Health Service System (HSS). The HSS administers non-pension benefits, including health, vision, dental and other benefits, such as life and long-term disability insurance. The Health Service Board adopts the annual health, vision, dental and other insurance plans, and the respective plan premiums and premium equivalents to be paid by HSS employers and members.

- HSS employers include the City and County of San Francisco (City), the San Francisco Unified School District (SFUSD), the San Francisco Community College District (SFCCD), and the San Francisco Superior Court (Superior Court).

- HSS members are active and retired employees of the above noted employers, their dependents, and members of eligible boards and commissions. Dependents include children, spouses, domestic partners, surviving spouses of deceased members, and other legal dependents.

City and Employee Contribution Models

Effective January 1, 2015, in accordance with most Memorandum of Understanding (MOUs) between the City and respective labor unions, the 10-county survey average was eliminated as the method for calculating employer contributions to the monthly health plan premiums for active employees. Instead, the City and most labor unions elected to use one of the following three percentage-based employee premium contribution models[1].

- Under the '93/93/83 Contribution Model', the City contributes up to 93 percent of the monthly premium for employee-only and employee plus one dependent coverage, capped at 93 percent of the second-highest cost plan. The City also contributes up to 83 percent of the monthly premium for employees with two or more dependents, capped at 83 percent of the second-highest cost plan.

[1] HSS advises that the 93/93/83 and the 100/96/83 Contribution Models are the most commonly used.

- Under the '100/96/83 Contribution Model', the City contributes 100 percent of monthly premiums for employee-only coverage. The City contributes up to 96 percent of the monthly premiums for employees with one dependent, capped at 96 percent of the second-highest cost plan. The City also contributes up to 83 percent of the monthly premium for employees with two or more dependents, capped at 83 percent of the second-highest cost plan.

- Under the '90/10 Contribution Model', the City contributes 90 percent of the monthly premium, capped at the second highest cost plan, provided that the City's premium contribution cannot fall below the lesser of the 10-county average survey. The calculation of the employee contribution for employee plus one or more dependents is determined by the specific MOUs.

10-County Survey Average

The 10-county survey average is still used as a basis for calculating the employer contribution to the monthly health plan premium for all retirees. Based on the survey, the 10-county average employer contribution for calendar year 2017 is $604.84 per member per month. The $604.84 per member per month is $25.60 or 4.4 percent more than the 10-county average monthly contribution of $579.24 in 2016.

Health Service System Trust Fund

Under Charter Section A8.428, employer and HSS member contributions to health plan premiums are deposited in the Health Service System Trust Fund. As of June 30, 2015, the Health Service System Trust Fund balance was $81,529,757.

DETAILS OF PROPOSED LEGISLATION

The proposed ordinance would (a) approve the Health Service System's health, vision, and dental plans as well as life insurance and long-term disability insurance plans and contribution rates for calendar year 2017 and (b) amend Administrative Code Section 16.703 to remove rates from the Code.

Currently, Section 16.703 of the City's Administrative Code states that contribution rates adopted by the Health Service Board for the Health Service System plans for specific calendar years, such as for calendar year 2016, are approved on a specified date. In prior years, the Board of Supervisors would amend this section of the Administrative Code and separately approve a resolution setting the employer's average contribution rates. The proposed ordinance would delete Section 16.703 of the Administrative Code. Instead, as in the proposed ordinance, the Board of Supervisors would approve Health Service System plans and contribution rates through an uncodified ordinance.

On June 21, 2016, the Health Service Board approved the following health, vision, dental, life and long-term disability insurance plans and premiums for the period from January 1, 2017 through December 31, 2017.

Health Plans

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

Consistent with the 2016 plan year, two HMOs will be offered to HSS members for the 2017 plan year: either Blue Shield of California or Kaiser Permanente. The Health Service Board added an acupuncture benefit and a third tier of copays for specialty drugs, excluding HIV drugs, to the Kaiser HMO Plan. No plan design changes were adopted for active and non-Medicare retirees in the Blue Shield HMO; however, the Health Service Board proposes to eliminate Blue Shield HMO for Medicare retirees due to a 10.2% proposed rate increase and offer Medicare retirees a choice between Kaiser's Medicare Advantage HMO or United Healthcare Medicare Advantage PPO, a New City Plan.

City Plan Preferred Provider Organization (PPO)[3]

The City Plan is a self-funded plan administered by United HealthCare (UHC). The Health Service Board adopted no plan design changes for the City Plan for active and early retirees in 2017. The previous City Plan Medicare coverage will no longer be available, such that Medicare retirees will be covered under a New City Plan, which has a wider coverage area.

New City Plan

In 2017, Medicare retirees will be offered coverage under the United Healthcare fully funded Medicare Advantage PPO called the New City Plan, formerly known as the United Health Care Medicare Advantage National PPO in 2016. The New City Plan has lower copays than the Blue Shield HMO for Medicare retirees.

Health Plan Premiums

Blue Shield Premiums in 2017

The Blue Shield HMO plan is a flex-funded plan for active and non-Medicare retiree members.[4] The Blue Shield monthly premium will increase in 2017 compared to 2016 by 4.26 percent for active employees and non-Medicare retirees.

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[2] A HMO (Health Maintenance Organization) offers care through a closed panel of providers, in which members select a primary care physician, who manages their care. The HMOs pay the medical groups on a per capita basis.

[3] Under a PPO, physicians, hospitals, and other providers are in network and paid by the purchaser (through a third party administrator) on a fee for service basis based on negotiated contracts.

[4] The Health Service Board adopted the flex-funded plan in 2012. The flex-funded plan differs from the fully-insured plan in that (1) under the fully insured plan, Blue Shield pays all covered claims, while (2) under the flex-funded plan HSS is responsible for paying both the per capita rate and the hospital claim costs. Blue Shield acts as a

Kaiser Premiums in 2017

The Kaiser Permanente premium rates for active employees, non-Medicare retirees and Medicare retirees in 2017 will increase by 5.46% from the 2016 rate.

City Plan Premiums in 2017

The City Plan is a self-funded plan in which overall monthly premiums are set based upon projected claims experience. The City Plan monthly premiums will result in overall increases of 16.65 percent, which includes active employees, non-Medicare retirees and the New City Plan. The Health Service Board approved a one-time buy-down of $3.79 million applied to active employees and non-Medicare retiree premiums to reduce their monthly rates and include administrative fee increase of 3% from 2016 to 2017. The New City Plan premium for a single Medicare retiree is 5.8 percent higher than the 2016 premium and 6 percent lower than the 2017 Kaiser Medicare rates.

Vision Plan

Members enrolled in one of the health plans receive vision benefits through Vision Service Plan (VSP), a third party insurer and a fully-funded plan. The cost of the vision plan is included in the cost of the medical plan for all monthly health plan premiums. VSP rates will decrease by 2.0% in plan year 2017 and are guaranteed through 2019.

Dental Plans

The Health Service System offers three dental plans, including one PPO (Delta Dental PPO) and two HMOs (Delta Care USA and United Healthcare Dental, formerly Pacific Union). United Healthcare will offer additional procedures in 2017. There are no plan changes in the other two dental plans. The City contributes part of the monthly premium for active employees. The City does not contribute to the monthly dental premium for retired employees.

- Premiums for 2017 for the Delta Care USA and United Healthcare Dental plans for active employees and retirees are unchanged from the 2016 plan year.
- Premiums for the self-funded Delta Dental PPO plan for active employees and early retirees will increase by 0.8 percent in 2017. Premiums for Delta Dental PPO for retirees are unchanged.

Life and Long-Term Disability (LSD) Insurance

The Health Service System will continue its contract with Aetna Life Insurance Company to provide life and long-term disability insurance in 2017. Premiums for long-term disability plans will decrease by 7.1% from 2016 rates and are guaranteed through 2019. Rates for

third party administrator negotiating capitation rates and hospital rates. If the claims experience exceeds 125% of premiums, Blue Shield pays the balance.

supplemental life insurance premiums paid by employees in 2017 will be split into tobacco and non-tobacco users, with premium decreases of 7.5% for non-tobacco users and varying increases by age for tobacco users. In 2017, supplemental life insurance will be offered to all City employees, resulting in higher costs.

Second Opinion Benefit Added

The Health Service Board approved a new medical second opinion benefit at a cost of $1.40 per member per month to enable covered members and dependents to contact a second opinion vendor, Best Doctors, an organization that has nationally renowned experts with extensive and specific medical expertise. This second opinion benefit should ensure that diagnosis and treatment plans are appropriate, cost-effective and least invasive based on clinical evidence.

Federal Affordable Care Act Requirements

According to the City's actuarial consultant, Aon Hewitt's June 28, 2016 memorandum to the Board of Supervisors, the Affordable Care Act previously imposed two direct fees and one tax on health plans, but only one fee is incorporated in the 2017 premiums, as discussed below.

- The Patient Centered Outcomes Research Institute Fee (PCORI) is a per enrollee per year fee assessed to health plans to fund health care research. This fee will remain at $2.25 in 2017 and is included in the projected 2017 premiums.

- The Transitional Reinsurance Fee (TRF) subsidizes reinsurance in the individual market, to lower the cost of health insurance for higher-risk individuals. The fee in 2016 was $27 per enrollee per year, except for Medicare enrollees. This fee is eliminated in 2017, such that no costs are assumed for 2017.

- The Health Insurance Tax (HIT) is applied to all fully insured or flex-funded plans, including vision and dental plans offered by HSS. The Federal Consolidated Appropriations Act of 2016 suspended collection of HIT for the 2017 calendar year. Therefore, no costs are assumed for 2017.

FISCAL IMPACT

Stabilization Reserve

HSS sets aside a portion of the Health Service System Trust Fund balance to stabilize the self-funded City Plan. The City Plan had a revenue surplus of $10,900,000 in 2014 that was deposited into the Stabilization Reserve, for a $25,800,000 balance. For 2015, $8,617,000, or one-third of the balance of $25,800,000, was allocated to lower City Plan premium rates, resulting in a remaining balance of $17,183,000. In 2016, $5,400,000 was transferred from the Stabilization Reserve to subsidize City and member contributions to the City Plan for active employees and non-Medicare retirees, further reducing this reserve to $11,783,000.

For 2017, based on Aon Hewitt's recommendations, the Health Service Board approved a $404,000 transfer from the Reserve to the Trust Fund reducing the balance to $11,379,000. In accordance with the Health Service Board's Self-Fund Plans' Stabilization Policy, one-third of the $11,379,000 balance or $3,790,000 was allocated to reduce active and early retiree City Plan member premiums. An additional one-time buy-down of $3,790,000 was approved by the Health Service Board to further reduce City Plan active employees and early retiree premiums. These 2017 transfers will result in a $3,799,000 remaining balance in the Stabilization Reserve.

2017 Total City Costs

As shown in Table 1 below, the total estimated City and member costs for health, vision, and dental plans, as well as long-term disability and life insurance, is $653,375,067 in 2017, which is a $29,862,936 or 4.79 percent increase from $623,512,131 in 2016.[5] The total estimated costs for the health, vision, and dental plans, as well as long-term disability and life insurance, for the City in 2017 is $581,013,572 which is a $24,282,943 or 4.36 percent increase from $556,730,628 in 2016.

Table 1: Total Plan Costs for the City, Employees and Retirees in 2017 Compared to 2016

	2016	2017	Increase/ (Decrease)	Percent
City Costs Only				
Kaiser HMO	$233,753,492	$246,554,108	$12,800,615	5.48%
Blue Shield HMO	241,768,265	247,884,794	6,116,529	2.53%
City Plan	30,109,753	34,905,753	4,796,000	15.93%
Subtotal Health and Vision Plan	505,631,510	529,344,655	23,713,145	4.69%
Dental	43,499,118	43,858,917	359,798	0.83%
Long Term Disability and Life Insurance	7,600,000	7,810,000	210,000	2.76%
Total City Costs	**$556,730,628**	**$581,013,572**	**24,282,943**	**4.36%**
Employee and Retiree Costs Only				
Kaiser HMO	27,683,334	29,168857	1,485,523	5.37%
Blue Shield HMO	31,314,362	32,250,007	935,645	2.99%
City Plan	3,977,127	4,855,951	878,825	22.10%
Subtotal Health and Vision Plan	62,974,823	66,274,816	3,299,993	5.24%
Dental	3,586,680	3,586,680	0	0.0%
Long Term Disability and Life Insurance	220,000	2,500,000	2,280,000	1,036.36%
Total Employee and Retiree Costs	**$66,781,503**	**$72,361,496**	**$5,570,993**	**8.36%**
Total Costs				
Kaiser HMO	261,436,827	275,722,965	14,286,138	5.46%
Blue Shield HMO	273,082,626	280,134,801	7,052,175	2.58%
City Plan	34,086,879	39,761,705	5,674,825	16.65%
Subtotal Health and Vision Plans	568,606,333	595,619,471	27,013,138	4.75%
Dental	47,085,798	47,445,597	359,798	0.76%
Long Term Disability and Life Insurance	7,820,000	10,310,000	2,490,000	31.84%
Total Costs	**$623,512,131**	**$653,375,067**	**$29,862,936**	**4.79%**

Source: Health Service System

[5] Differences between the 2016 estimates included here and those used in the Budget and Legislative Analyst's report in July 2015 are due to updated Census figures (as of June, 2016) used by the Health Service System to produce their estimates of how many members will enroll in each plan.

The employer contribution amounts shown in Table 1 above are included in the FY 2016-17 and FY 2017-18 budgets currently pending before the Board of Supervisors.

The balance of $72,361,496 ($653,375,067 total 2017 City and member costs less $581,013,572 City 2017 costs) is paid by employees and retirees. The Attachment to this report shows the City and employee monthly premium contributions for the '93/93/83 Contribution Model' and '100/96/83 Contribution Model' noted above. As shown in the Attachment, with the exception of Kaiser, under both contribution models negotiated as part of the MOUs, the City pays more for the employer contribution than under the 10-county survey average amount of $604.84.

RECOMMENDATION

Approve the proposed ordinance.

Attachment
Page 1 of 2

93/93/83 Contribution Model

	City Plan			Kaiser			Blue Shield		
Members	Employee	Employee + 1 Dependent	Employee +2 or More Dependents	Employee	Employee + 1 Dependent	Employee +2 or More Dependents	Employee	Employee + 1 Dependent	Employee +2 or More Dependents
Plan Year 2016	$85.65	$144.72	$414.13	$38.78	$77.42	$265.91	$50.51	$100.87	$346.50
Plan Year 2017	$102.81	$166.01	$430.34	$40.78	$81.25	$278.90	$52.66	$105.01	$360.53
$ Increase/ (Decrease)	$17.16	$21.29	$16.21	$2.00	$3.83	$12.99	$2.15	$4.14	$14.03
% Increase/ (Decrease)	20.04%	14.71%	3.91%	5.16%	4.95%	4.89%	4.26%	4.10%	4.05%
Employer									
Plan Year 2016	$671.02	$1,340.20	$1,691.74	$515.24	$1,028.59	$1,298.25	$671.02	$1,340.20	$1,691.74
Plan Year 2017	$699.59	$1,395.08	$1,760.23	$541.76	$1,079.45	$1,361.67	$699.59	$1,395.08	$1,760.23
$ Increase/ (Decrease)	$28.57	$54.88	$68.49	$26.52	$50.86	$63.42	$28.57	$54.88	$68.49
% Increase/ (Decrease)	4.26%	4.09%	4.05%	5.15%	4.94%	4.89%	4.26%	4.09%	4.05%
Total									
Plan Year 2016	$756.67	$1,484.92	$2,105.87	$554.02	$1,106.01	$1,564.16	$721.53	$1,441.07	$2,038.24
Plan Year 2017	$802.40	$1,561.09	$2,190.57	$582.54	$1,160.70	$1,640.57	$752.25	$1,500.09	$2,120.76
$ Increase/ (Decrease)	$45.73	$76.17	$84.70	$28.52	$54.69	$76.41	$30.72	$59.02	$82.52
% Increase/ (Decrease)	6.04%	5.13%	4.02%	5.15%	4.94%	4.89%	4.26%	4.10%	4.05%

100/96/83 Contribution Model

	City Plan			Kaiser			Blue Shield		
	Employee	Employee + 1 Dependent	Employee +2 or More Dependents	Employee	Employee + 1 Dependent	Employee +2 or More Dependents	Employee	Employee + 1 Dependent	Employee +2 or More Dependents
Members									
Plan Year 2016	$0.00	$101.49	$414.13	$0.00	$44.24	$265.91	$0.00	$57.64	$346.50
Plan Year 2017	$0.00	$121.00	$430.34	$0.00	$46.43	$278.90	$0.00	$60.00	$360.53
$ Increase/ (Decrease)	$0.00	$19.51	$16.21	$0.00	$2.19	$12.99	$0.00	$2.36	$14.03
% Increase/ (Decrease)		19.22%	3.91%	0.00%	4.95%	4.89%	0.00%	4.09%	4.05%
Employer									
Plan Year 2016	$756.67	$1,383.43	$1,691.74	$554.02	$1,061.77	$1,298.25	$721.53	$1,383.43	$1,691.74
Plan Year 2017	$802.40	$1,440.09	$1,760.23	$582.54	$1,114.27	$1,361.67	$752.25	$1,440.09	$1,760.23
$ Increase/ (Decrease)	$45.73	$56.66	$68.49	$28.52	$52.50	$63.42	$30.72	$56.66	$68.49
% Increase/ (Decrease)	6.04%	4.10%	4.05%	5.15%	4.94%	4.89%	4.26%	4.10%	4.05%
Total									
Plan Year 2016	$756.67	$1,484.92	$2,105.87	$554.02	$1,106.01	$1,564.16	$721.53	$1,441.07	$2,038.24
Plan Year 2017	$802.40	$1,561.09	$2,190.57	$582.54	$1,160.70	$1,640.57	$752.25	$1,500.09	$2,120.76
$ Increase/ (Decrease)	$45.73	$76.17	$84.70	$28.52	$54.69	$76.41	$30.72	$59.02	$82.52
% Increase/ (Decrease)	6.04%	5.13%	4.02%	5.15%	4.94%	4.89%	4.26%	4.10%	4.05%

2016 10-County Survey

2016 HSS Active Employee Plans	Kaiser HMO	Blue Shield HMO	City Health Plan PPO
Annual Deductible	N/A	N/A	$250/$500/$750
Hospital (Inpatient)	$100 Copay	$200 Copay	85%/15% - In 50%/50% - Out
Emergency Room	$100 Copay Waived if Admitted	$100 Copay Waived if Admitted	85%/15%
Ambulance Services	No Charge	No Charge	85%/15%
Office Visits	$20 Copay	$25 Copay	85%/15% - In 50%/50% - Out
Urgent Care	$20 Copay	$25 Copay	85%/15% - In 50%/50% - Out
Rx - Retail 30-day supply	$5/$15	$10/$25/$50	$5/$20/$45 - In 50% after $5/$20/$45 - Out
Rx - Mail Order 90-day supply	$10/$30	$20/$50/$100	$10/$40/$90 - In Not covered - Out
Infertility Treatment	50%/50%	50%/50%	50%/50%
Acupuncture	Not Covered	$15 Copay Limit 30 Visits/Yr	50%/50% Limit $1,000 Max/Yr
Chiropractic	$15 Copay Limit 30 Visits/Yr	$15 Copay Limit 30 Visits/Yr	50%/50% Limit $1,000 Max/Yr

For informational purposes only. HSS data is not included in the 10-County Survey.
City Health Plan is administered by UnitedHealthcare.

2016 10-County Survey

2016 CalPERS												
	Kaiser HMO	Blue Shield Access+ HMO	Blue Shield Net-Value HMO	PERS Select In	PERS Select Out	PERS Choice In	PERS Choice Out	PERS Care In	PERS Care Out	Anthem Blue Cross EPO and HMO	Health Net EPO and HMO
Annual Deductible	N/A	N/A	N/A	$500/$1,000		$500/$1,000		$500/$1,000		N/A	N/A
Hospital (Inpatient)	No Charge	No Charge	No Charge	80%/ 20%	60%/ 40%	80%/ 20%	60%/ 40%	90%/ 10% $250 Deductible	60%/ 40%	No Charge	No Charge
Emergency Room	$50 Copay Waived if Admitted	$50 Copay Waived if Admitted	$50 Copay Waived if Admitted	80%/20% $50 Deductible		80%/20% $50 Deductible		90%/10% $50 Deductible		$50 Copay Waived if Admitted	$50 Copay Waived if Admitted
Office Visits	$15 Copay	$15 Copay	$15 Copay	$20 Copay	60%/ 40%	$20 Copay	60%/ 40%	$20 Copay	60%/ 40%	$15 Copay	$15 Copay
Urgent Care	$15 Copay	$15 Copay	$15 Copay	$20 Copay	60%/ 40%	$20 Copay	60%/ 40%	$20 Copay	60%/ 40%	$15 Copay	$15 Copay
Rx Retail	$5/$20	$5/$20/$50	$5/$20/$50	$5/$20/$50		$5/$20/$50		$5/$20/$50		$5/$20/$50	$5/$20/$50
Rx Mail Order	$10/$40	$10/$40/$100	$10/$40/$100	$10/$40/$100		$10/$40/$100		$10/$40/$100		$10/$40/$100	$10/$40/$100
Infertility Treatment	50%/50%	50%/50%	50%/50%	Not Covered		Not Covered		Not Covered		50%/50%	50%/50%
Acupuncture	$15 Copay Limit 20 Visits/Yr	$15 Copay Limit 20 Visits/Yr	$15 Copay Limit 20 Visits/Yr	$15 Copay Limit 20 visits per year	60%/ 40%	$15 Copay Limit 20 visits per year	60%/ 40%	$15 Copay Limit 20 visits per year	60%/ 40%	$15 Copay Limit 20 visits per year	$15 Copay Limit 20 visits per year
Chiropractic	$15 Copay Limit 20 Visits/Yr	$15 Copay Limit 20 Visits/Yr	$15 Copay Limit 20 Visits/Yr	$15 Copay Limit 20 visits per year	60%/ 40%	$15 Copay Limit 20 visits per year	60%/ 40%	$15 Copay Limit 20 visits per year	60%/ 40%	$15 Copay Limit 20 visits per year	$15 Copay Limit 20 visits per year

For informational purposes only. CalPERS data is not included in the 10-County Survey.

2016 10-County Survey

10. Fresno County						Population: 965,000
Medical Plans	2015 Premium	2016 Premium	% +/-	2015 County Contribution	2016 County Contribution	% +/-
Kaiser $15 HMO	652.80	703.51	7.8%	483.17	483.17	0.0%
Blue Cross HMO	652.80	736.72	12.9%	483.17	483.17	0.0%
Blue Cross PPO	901.92	948.14	5.1%	483.17	483.17	0.0%
Blue Cross HDPPO	517.53	544.93	5.3%	483.17	483.17	0.0%
AVERAGE	**681.26**	**733.32**	**7.6%**	**483.17**	**483.17**	**0.0%**

10. Fresno County: Medical Plan Design Summary		
Kaiser	HMO	
Deductible	None	
Physicians Services	$15 per visit	
Emergency Room	$100 per visit	
Rx	$10/$20	
Hospital	No Charge	
BLUE CROSS	HMO	PPO
Deductible	None	$250/$500
Physicians Services	$15 per visit	$20 per visit
Emergency Room	$100 per visit	$100 deductible
Rx	$10/$20/$35	$10/$20/$35
Hospital	No Charge	No Charge
BLUE CROSS	HDPPO - IN	
Deductible	$3,000/$6,000	
Physicians Services	$0 Copay After Ded	
Emergency Room	$0 Copay After Ded	
Rx	$0 Copay After Ded	
Hospital	$0 Copay After Ded	

2016 10-County Survey

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	No Charge			
Rx	No Charge	$3 Per Rx			
Hospital	No Charge	No Charge			
HealthNet HMO	**HMO**	**Plan A-In**	**Plan A-Out**	**Plan B-In**	**Plan B-Out**
Deductible	None	$250/$750	$250/$750	$500/$1,500	$500/$1,500
Physicians Services	$10/$20 Copay	$10 Copay	70/30	$20 Copay	60/40
Emergency Room	$25	$50 + 10% co-ins	$50 + 10% co-ins	80/20	80/20
Rx	$10/$20/$35	$5	$5	$10/$20/$35	$10/$20/$35
Hospital	No Charge	90/10	70/30	80/20	60/40
Kaiser	**Plan A**	**Plan B**			
Deductible	None	$500/$1,000			
Physicians Services	$10 Copay	$20 Copay			
Emergency Room	$10 Copay	90/10 After Ded			
Rx	$10/$20	$10/$30			
Hospital	No Charge	90/10 After Ded			

2016 10-County Survey

9. Contra Costa County						Population: 1,111,000
Medical Plans	2015 Premium	2016 Premium	% +/-	2015 County Contribution	2016 County Contribution	% +/-
CCHP Plan A	654.44	683.07	4.4%	583.93	583.97	0.0%
CCHP Plan B	725.46	757.20	4.4%	597.59	614.89	2.9%
Health Net HMO Plan A	1,184.71	1,251.53	5.6%	809.83	796.62	-1.6%
Health Net HMO Plan B	823.83	870.29	5.6%	627.79	669.94	6.7%
Health Net PPO Plan A	1,520.06	1,671.46	10.0%	729.85	751.80	3.0%
Health Net PPO Plan B	1,368.43	1,504.73	10.0%	604.60	660.12	9.2%
Kaiser HMO Plan A	811.33	784.62	-3.3%	580.92	546.15	-6.0%
Kaiser HMO Plan B	637.55	621.16	-2.6%	478.91	483.08	0.9%
Blue Shield HMO - PERS	928.87	1,016.18	9.4%	624.59	633.14	1.4%
CCHP Plan A Alternate - PERS	772.95	837.46	8.3%	589.39	602.38	2.2%
Kaiser HMO - PERS	714.45	746.47	4.5%	584.42	588.59	0.7%
PERS Care	775.08	889.27	14.7%	597.83	614.67	2.8%
PERS Choice	700.84	798.36	13.9%	583.88	610.07	4.5%
PORAC - PERS	675.00	699.00	3.6%	583.52	593.33	1.7%
PERS Select	690.43	730.07	5.7%	578.72	590.47	2.0%
Blue Shield HMO NetValue - PERS	870.60	1,033.86	18.8%	618.00	662.59	7.2%
AVERAGE	**865.88**	**930.92**	**7.5%**	**610.86**	**625.11**	**2.3%**

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2016 10-County Survey

8. Sacramento County						Population: 1,482,000
Medical Plans	2015 Premium	2016 Premium	% +/-	2015 County Contribution	2016 County Contribution	% +/-
Western Health Adv. HMO	649.74	680.44	4.7%	649.74	680.44	4.7%
Sutter Health Plus HMO	631.22	654.60	3.7%	631.22	654.60	3.7%
Kaiser HMO 15	626.38	659.34	5.3%	626.38	659.34	5.3%
Western Health Adv. HDHP	496.30	520.00	4.8%	496.30	520.00	4.8%
Sutter Health Plus HDHP	491.64	510.08	3.8%	491.64	510.08	3.8%
Kaiser HDHP HMO	493.74	519.80	5.3%	493.74	519.80	5.3%
AVERAGE	**564.84**	**590.71**	**4.6%**	**564.84**	**590.71**	**4.6%**

8. Sacramento County: Medical Plan Design Summary		
Sutter Health Plus	HMO	HDHP - HMO
Deductible	None	$1,500/$3,000
Physicians Services	$15 Copay	No Charge After Ded
Emergency Room	$35 Copay	No Charge After Ded
Rx	$10/$20/$35	No Charge After Ded
Hospital	No Charge	No Charge After Ded
Western Health Advantage	HMO	HDHP - HMO
Deductible	None	$1,500/$3,000
Physicians Services	$15 Copay	No Charge After Ded
Emergency Room	$35 Copay	No Charge After Ded
Rx	$10/$20/$35	No Charge After Ded
Hospital	No Charge	No Charge After Ded
Kaiser	HMO	HDHP - HMO
Deductible	None	$1,500/$3,000
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

2016 10-County Survey

7. Alameda County						Population: 1,610,000
Medical Plans	2015-16 Premium	2016-17 Premium	% +/-	2015-16 County Contribution	2016-17 County Contribution	% +/-
UnitedHealthcare Premium HMO	972.34	982.06	1.0%	875.12	883.86	1.0%
Kaiser Premium HMO	637.06	641.06	0.6%	573.36	576.96	0.6%
Kaiser Standard HMO	592.20	595.92	0.6%	532.98	536.32	0.6%
UnitedHealthcare PPO	2,341.06	2,570.50	9.8%	573.36	576.96	0.6%
UnitedHealthcare Standard HMO	868.88	877.56	1.0%	782.00	789.80	1.0%
AVERAGE	**1,082.31**	**1,133.42**	**4.7%**	**667.36**	**672.78**	**0.8%**

7. Alameda County: Medical Plan Design Summary			
United Healthcare	PPO	Premium HMO	Standard HMO
Deductible	$2,000/$4,000	None	None
Physicians Services	$25 Copay	$15 Copay	$40 Copay
Emergency Room	$250 Copay	$50 Copay	$100 Copay
Rx	$10/$30/$50	$10/$25/$35	$25/$35/$50
Hospital	$500 Ded	No Charge	$500 Copay
Kaiser	Premium HMO	Standard HMO	
Deductible	None	None	
Physicians Services	$15 Copay	$40 Copay	
Emergency Room	$50 Copay	$100 Copay	
Rx	$15/$15	$15/$30	
Hospital	No Charge	$500 Copay	

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* Discontinued in 2015-16

2016 10-County Survey

6. Santa Clara County						Population: 1,894,000
Medical Plans	2014-15 Premium	2015-16 Premium	% +/-	2014-15 County Contribution	2015-16 County Contribution	% +/-
Kaiser HMO	686.08	679.08	-1.0%	672.35	665.49	-1.0%
Valley Health HMO	710.32	852.39	20.0%	692.77	783.25	13.1%
Health Net POS	1,000.48	1,091.03	9.1%	875.67	1,069.21	22.1%
AVERAGE	**798.96**	**874.16**	**9.4%**	**746.93**	**839.32**	**12.4%**

6. Santa Clara County: Medical Plan Design Summary			
Kaiser	HMO		
Deductible	None		
Physicians Services	$10 Copay		
Emergency Room	$35 Copay		
Rx	$5/$10		
Hospital	$100 per admit		
Valley Health	HMO		
Deductible	None		
Physicians Services	No Charge		
Emergency Room	No Charge		
Rx	No Charge		
Hospital	No Charge		
HealthNet POS	HMO	PPO	OUT
Deductible	None	None	$200/PMPY
Physicians Services	$15 Copay	$20 Copay	70/30
Emergency Room	$50 Copay	$75 Copay	70/30
Rx	$5/$15/$30	$5/$15/$30	$5/$15/$30
Hospital	No Charge	90/10	70/30

2016 10-County Survey

5. San Bernardino County						Population: 2,112,000
Medical Plans	2014-15 Premium	2015-16 Premium	% +/-	2014-15 County Contribution	2015-16 County Contribution	% +/-
Kaiser HMO	582.92	575.62	-1.3%	425.60	420.95	-1.1%
Blue Shield Signature HMO	473.55	488.06	3.1%	389.80	390.90	0.3%
Blue Shield Needles PPO	974.13	1,022.04	4.9%	423.33	418.98	-1.0%
Blue Shield PPO	863.27	905.69	4.9%	423.33	418.98	-1.0%
AVERAGE	**723.47**	**747.85**	**3.4%**	**415.52**	**412.45**	**-0.7%**

5. San Bernardino County: Medical Plan Design Summary		
Kaiser	HMO	
Deductible	None	
Physicians Services	$10 Copay	
Emergency Room	$50 Copay	
Rx	$10/$15	
Hospital	No Charge	
Blue Shield Signature HMO	Tier 1 - HMO	Tier 2 - PPO
Deductible	None	None
Physicians Services	$10 Copay	$30 Copay
Emergency Room	$50 Copay	$50 Copay
Rx	$5/$10/$25	Not covered
Hospital	No Charge	Not covered
Blue Shield PPO	PPO - In	PPO - Out
Deductible	$250/$500	$250/$500
Physicians Services	$10 Copay	70/30 After ded
Emergency Room	$50 Copay plus 20% After Ded	$50 Copay plus 20% After Ded
Rx	$15/$30/$30	$15/$30/$30 + 25% of billed amount
Hospital	80/20 After Ded	70/30 After Ded
Blue Shield Needles PPO	PPO - In	PPO - Out
Deductible	None	$250/$750
Physicians Services	$10 Copay	70/30 After Ded
Emergency Room	$50 Copay	$50 Copay
Rx	$10/$15/$15	$10/$15/$15+25% of billed amount
Hospital	No charge	70/30 After Ded

2016 10-County Survey

4. Riverside County: Medical Plan Design Summary			
UHC	**HMO**	**PPO - In**	**PPO - Out**
Deductible	None	$500/$1,000	$500/$1,000
Physicians Services	$15 Copay	$20 Copay	40% After Ded
Emergency Room	$100 Copay	$50 Copay	$50 Copay
Rx	$10/$25/$50	$5/$15/$45	$5/$15/$45
Hospital	$100 Copay	80/20 After ded	60/40 After ded
Kaiser	**HMO**		
Deductible	None		
Physicians Services	$15 Copay		
Emergency Room	$100 Copay		
Rx	$10/$25		
Hospital	$100 Copay		
Exclusive Care	**EPO**		
Deductible	None		
Physicians Services	$15 Copay		
Emergency Room	$100 Copay		
Rx	$10/$25/$50		
Hospital	$100 Copay		

2016 10-County Survey

4. Riverside County						Population: 2,329,000
Medical Plans	2015 Premium	2016 Premium	% +/-	2015 County Contribution	2016 County Contribution	% +/-
UHC HMO	628.84	670.90	6.7%	628.84	670.90	6.7%
Kaiser HMO	616.50	603.52	-2.1%	616.50	603.52	-2.1%
Exclusive Care EPO	468.88	497.08	6.0%	468.88	497.08	6.0%
UHC PPO	966.24	1,057.00	9.4%	805.44	805.44	0.0%
Blue Shield HMO - PERS	598.66	654.88	9.4%	598.66	654.88	9.4%
Kaiser HMO - PERS	579.80	605.06	4.4%	579.80	605.06	4.4%
PERSCare	657.32	761.50	15.8%	657.32	761.50	15.8%
PERS Choice	594.40	683.72	15.0%	594.40	683.72	15.0%
PORAC - PERS	675.00	699.00	3.6%	675.00	699.00	3.6%
Blue Shield HPN	561.10	666.36	18.8%	561.10	666.36	18.8%
PERS Select	586.32	625.20	6.6%	586.32	625.20	6.6%
Anthem Select HMO	653.98	634.76	-2.9%	653.98	634.76	-2.9%
Anthem Traditional HMO	743.12	710.78	-4.4%	743.12	710.78	-4.4%
Health Net Salud y Mas	520.60	535.98	3.0%	520.60	535.98	3.0%
Health Net SmartCare	579.88	596.98	2.9%	579.88	596.98	2.9%
Sharp	564.58	561.34	-0.6%	564.58	561.34	-0.6%
UnitedHealthcare	449.10	494.00	10.0%	449.10	494.00	10.0%
AVERAGE	**614.37**	**650.47**	**5.9%**	**604.91**	**635.68**	**5.1%**

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2016 10-County Survey

3. Orange County						Population: 3,145,000
Medical Plans	2015 Premium	2016 Premium	% +/-	2015 County Contribution	2016 County Contribution	% +/-
Choice Wellwise PPO*	764.40	741.47	-3.0%	687.96	668.01	-2.9%
Choice Sharewell PPO*	305.76	296.59	-3.0%	374.79	365.62	-2.4%
CIGNA HMO Choice*	645.88	638.52	-1.1%	581.29	574.67	-1.1%
Kaiser HMO Choice*	482.33	508.05	5.3%	434.10	457.25	5.3%
AVERAGE	**549.59**	**546.16**	**-0.6%**	**519.54**	**516.39**	**-0.6%**

3. Orange County: Medical Plan Design Summary		
Wellwise PPO	In	Out
Deductible	$500/$1,000	$750/$1,500
Physicians Services	90/10	70/30
Emergency Room	90/10	90/10
Rx	20%/25%/30%	Not Covered
Hospital	90/10	70/30
Sharewell PPO	In	Out
Deductible	$5,000 Per Family	$5,000 Per Family
Physicians Services	90/10	70/30
Emergency Room	90/10	70/30
Rx	80/20	80/20
Hospital	90/10	70/30
CIGNA	HMO	
Deductible	None	
Physicians Services	$20 Copay	
Emergency Room	$50 Copay	
Rx	$10/$30/$50	
Hospital	$100 Per Admit	
Kaiser	HMO	
Deductible	None	
Physicians Services	$20 Copay	
Emergency Room	$50 Copay	
Rx	$10/$30	
Hospital	$100 Per Admit	

* Orange County modified plan designs and contributions in 2015 plan year to address increasing healthcare costs and facilitate wellness participation. Current county contributions assume wellness participation.

2016 10-County Survey

2. San Diego County: Medical Plan Design Summary		
Anthem - Blue Cross HMO	Select HMO	Full Access HMO
Deductible	None	None
Physicians Services	$25 Copay	$30 Copay
Emergency Room	$125 Copay	$125 Copay
Rx	$10/$20/$35	$10/$20/$35
Hospital	$200 Copay Per Admit	$200 Copay Per Admit
Anthem - Blue Cross High Deductible	PPO - In	Out
Deductible	$1,500/$3,000	$3,000/$6,000
Physicians Services	10% After Ded	30% After Ded
Emergency Room	10% After Ded	10% After Ded
Rx	$10/$30/$50	30%, 100% Over The Max.
Hospital	10% After Ded	30% After Ded

2016 10-County Survey

2. San Diego County						Population: 3,263,000
Medical Plans	2015 Premium	2016 Premium	% +/-	2015 County Contribution	2016 County Contribution	% +/-
Kaiser HMO	428.10	459.96	7.4%	428.10	459.96	7.4%
Kaiser High Deductible	334.18	359.06	7.4%	334.18	359.06	7.4%
Anthem - Blue Cross PPO	871.94	1,106.74	26.9%	516.17	541.83	5.0%
Anthem - Blue Cross Select HMO	589.08	571.52	-3.0%	516.17	541.83	5.0%
Anthem - Blue Cross Full Access HMO	1,309.30	1,332.54	1.8%	516.17	541.83	5.0%
Anthem - Blue Cross High Deductible	599.98	864.94	44.2%	516.17	541.83	5.0%
AVERAGE	**688.76**	**782.46**	**13.6%**	**471.16**	**497.72**	**5.6%**

2. San Diego County: Medical Plan Design Summary		
Kaiser HMO	HMO	
Deductible	None	
Physicians Services	$25 Copay	
Emergency Room	$125 Copay	
Rx	$10/$20/$30	
Hospital	$100 Copay Per Admit	
Kaiser High Deductible	HD w/HSA	
Deductible	$1,500/$3,000	
Physicians Services	10% After Ded	
Emergency Room	10% After Ded	
Rx	$10/$20/$30	
Hospital	10% After Ded	
Anthem - Blue Cross PPO	PPO - In	Out
Deductible	$300/$600	$600/$1,200
Physicians Services	$20 Copay	40% After Ded
Emergency Room	$75 Copay then 20%	$75 Copay then 20%
Rx	$10/$20/$35	$10/$20/$35
Hospital	$150 Copay then 20%	$300 Copay then 40%

2016 10-County Survey

1. Los Angeles County: Medical Plan Design Summary				
Blue Cross Prudent Buyer PPO	ALADS - In	ALADS - Out	Unrep - In	Unrep - Out
Deductible	$300/$900	$300/$900	$150/$400	$400/$800
Physician Services	90/10 After Ded	70/30 After Ded	$15 Copay	70/30 After Ded
Emergency Room	90/10 After Ded	90/10 After Ded	$50 Copay Then 90/10 After Ded	$50 Copay Then 90/10 After Ded
Rx	$5/$15	$5/$15+50%	$10/$20	$10/$20
Hospital	90/10 After Ded	70/30 After Ded	90/10 After Ded	70/30 After Ded + $500/Admit

2016 10-County Survey

1. Los Angeles County: Medical Plan Design Summary			
CIGNA	**HMO**	**POS - In**	**POS - Out**
Deductible	None	None	$500/$1,000
Physicians Services	$10 Copay	$10 Copay	60/40 After Ded
Emergency Room	$50 Copay	$50 Copay	$50 Copay
Rx	$5/$20	$5/$20	60/40 After Ded
Hospital	No Charge	$50 Copay/Day	60/40 After Ded + $1,000/Admit
Blue Cross California Care HMO	**ALADS**	**Unrep**	
Deductible	None	None	
Physicians Services	$10 Copay	$15 Copay	
Emergency Room	$25 Copay	$50 Copay	
Rx	$5/$15	$10/$20	
Hospital	No Charge	No Charge	
Blue Cross Plus POS	**HMO**	**In**	**Out**
Deductible	None	None	$400/$800
Physicians Services	$15 Copay	$25 Copay	70/30 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 After Ded
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	$2,000/$4,000		
Physicians Services	75/25 After Ded		
Emergency Room	$100 Copay then 75/25 After Ded		
Rx	$200 Ded Then 75/25 After Ded		
Hospital	75/25 After Ded +$500/Admit		

2016 10-County Survey

1. Los Angeles County: Medical Plan Design Summary			
Blue Shield Lite	**HMO**	**In**	**Out**
Deductible	None	$400/$800	$400/$800
Physicians Services	$10 Copay	$25 Copay	70/30 After Ded
Emergency Room	$50 Copay	$50 Copay	$50 Copay
Rx	$5/$15/$30	$5/$15/$30	Not Covered
Hospital	No Charge	80/20 After Ded	70/30 After Ded
Blue Shield Classic	**HMO**	**In**	**Out**
Deductible	None	$300/$600	$300/$600
Physicians Services	$10 Copay	$20 Copay	70/30 After Ded
Emergency Room	$50 Copay	$50 Copay	$50 Copay
Rx	$5/$15/$30	$5/$15/$30	Not Covered
Hospital	No Charge	90/10 After Ded	70/30 After Ded
PacifiCare(UnitedHealthcare Options)	**HMO**		
Deductible	None		
Physicians Services	$10 Copay		
Emergency Room	$50 Copay		
Rx	$5/$20		
Hospital	No Charge		
UnitedHealthcare		**PPO - In**	**PPO - Out**
Deductible		$300/$1,500	$1,500/$3,000
Physicians Services		20% Copay	50% Copay After Ded
Emergency Room		20% Copay After Ded	50% Copay After Ded
Rx		$5/$20/$35	Not Covered
Hospital		20% Copay After Ded	50% Copay After Ded
Kaiser	**Options HMO**	**Choices HMO**	**Unrep HMO**
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

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2016 10-County Survey

1. Los Angeles County						Population: 10,116,000
Medical Plans	2015 Premium	2016 Premium	% +/-	2015 County Contribution	2016 County Contribution	% +/-
Kaiser Choices HMO - County Sponsored	637.71	661.86	3.8%	637.71	661.86	3.8%
CIGNA Choices HMO - County Sponsored	700.16	747.89	6.8%	700.16	747.89	6.8%
CIGNA Choices POS - County Sponsored	1,259.23	1,345.81	6.9%	812.00	860.72	6.0%
Blue Cross Prudent Buyer Basic- ALADS	917.42	968.94	5.6%	812.00	860.72	6.0%
Blue Cross CaliforniaCare Basic- ALADS	621.62	656.05	5.5%	621.62	656.05	5.5%
Blue Cross Prudent Buyer Premier- ALADS	1,039.09	1,092.90	5.2%	812.00	860.72	6.0%
Blue Cross CaliforniaCare Premier - ALADS	743.29	780.01	4.9%	743.29	780.01	4.9%
Blue Shield Classic CAPE	832.00	878.00	5.5%	812.00	860.72	6.0%
Blue Shield Lite CAPE	512.00	536.00	4.7%	512.00	536.00	4.7%
Local 1014 Plan - Fire Fighters	723.00	758.00	4.8%	723.00	758.00	4.8%
Kaiser Options - SEIU	599.92	623.40	3.9%	599.92	623.40	3.9%
Kaiser HMO - Unrepresented	257.00	272.00	5.8%	257.00	272.00	5.8%
Blue Cross CaliforniaCare HMO - Unrepresented	257.00	272.00	5.8%	257.00	272.00	5.8%
Blue Cross Plus POS - Unrepresented	389.00	411.00	5.7%	389.00	411.00	5.7%
Blue Cross Catastrophic - Unrepresented	199.00	93.00	-53.3%	199.00	93.00	-53.3%
Blue Cross Prudent Buyer PPO - Unrepresented	498.00	526.00	5.6%	498.00	526.00	5.6%
UnitedHealthcare Options HMO - SEIU	621.24	660.44	6.3%	621.24	660.44	6.3%
UnitedHealthcare Options PPO - SEIU	1,737.75	2,085.86	20.0%	812.00	852.60	5.0%
AVERAGE	**696.91**	**742.73**	**6.6%**	**601.05**	**627.40**	**4.4%**

2016 10-County Survey

Average of Employer Contributions

	County	2006 2007	2007 2008	2008 2009	2009 2010	2010 2011	2011 2012	2012 Jul–Dec	2013	2014	2015	2016 Calculated	2016 Actual	3 Yr Trend	Months of Trend	Trend Factor	2017 Calculated
1	Los Angeles	338.55	362.55	383.10	415.91	457.56	478.56	499.57	515.07	552.40	610.75	619.87	627.40	6.8%	6	1.03	648.37
2	San Diego	363.48	305.87	327.00	363.48	364.00	406.00	432.20	444.86	445.29	460.51	477.99	497.72	3.8%	6	1.02	507.13
3	Orange	380.63	387.92	338.64	372.44	383.75	434.41	485.10	506.94	544.46	567.79	525.51	516.39	0.6%	6	1.00	517.98
4	Riverside	391.53	462.05	469.65	491.27	488.44	513.02	537.43	545.54	606.39	587.21	616.96	635.68	5.2%	6	1.03	652.09
5	San Bernardino*	299.72	313.73	368.67	377.35	397.51	399.70	398.98	398.98	413.51	420.92	421.18	412.45	1.1%	12	1.01	417.04
6	Santa Clara*	438.49	479.93	515.52	563.19	608.44	655.97	643.13	643.13	656.34	776.62	785.13	839.32	9.3%	12	1.09	917.21
7	Alameda	342.11	398.35	440.58	497.76	521.89	541.06	575.00	588.99	638.47	622.92	684.14	672.78	4.5%	6	1.02	687.86
8	Sacramento	422.13	480.54	480.76	516.78	561.35	637.98	667.02	696.00	714.53	535.31	549.40	590.71	-5.3%	6	0.97	574.78
9	Contra Costa	366.77	407.86	438.47	470.02	495.15	521.90	540.43	553.15	574.27	607.18	623.46	625.11	4.2%	6	1.02	637.99
10	Fresno	390.06	432.64	425.58	425.43	450.43	450.80	450.80	455.17	450.86	488.79	488.79	483.17	2.0%	6	1.01	488.00
	Average	**373.35**	**403.14**	**418.80**	**449.37**	**472.85**	**503.94**	**522.97**	**534.78**	**559.65**	**567.80**	**579.24**	**590.07**	**3.3%**	**9.0**	**1.03**	**604.84**

Increase Over Prior Year

	County	2006 2007	2007 2008	2008 2009	2009 2010	2010 2011	2011 2012	2012 Jul–Dec	2013	2014	2015	2016	2017
1	Los Angeles	7.11%	7.09%	5.67%	8.57%	10.01%	4.60%	4.39%	3.10%	7.25%	10.56%	1.49%	4.60%
2	San Diego	35.70%	-15.85%	6.91%	11.16%	0.14%	11.50%	6.45%	2.93%	0.10%	3.42%	3.80%	6.10%
3	Orange	1.74%	1.92%	-12.70%	9.98%	3.04%	13.20%	11.67%	4.50%	7.40%	4.28%	-7.45%	-1.43%
4	Riverside	7.36%	18.01%	1.65%	4.60%	-0.57%	5.00%	4.76%	1.51%	11.15%	-3.16%	5.07%	5.69%
5	San Bernardino	-10.15%	4.67%	17.51%	2.35%	5.34%	0.60%	-0.18%	0.00%	3.64%	1.79%	0.06%	-0.98%
6	Santa Clara	14.69%	9.45%	7.42%	9.25%	8.04%	7.80%	-1.96%	0.00%	2.05%	18.33%	1.10%	16.82%
7	Alameda	8.13%	16.44%	10.60%	12.98%	4.85%	3.70%	6.27%	2.43%	8.40%	-2.44%	9.83%	0.54%
8	Sacramento	16.00%	13.84%	0.05%	7.49%	8.62%	13.70%	4.55%	4.34%	2.66%	-25.08%	2.63%	4.62%
9	Contra Costa	8.96%	11.20%	7.51%	7.20%	5.35%	5.40%	3.55%	2.35%	3.82%	5.73%	2.68%	2.33%
10	Fresno	-2.41%	10.92%	-1.63%	-0.03%	5.87%	0.10%	0.00%	0.97%	-0.95%	8.41%	0.00%	-0.16%
	Average	**8.05%**	**7.98%**	**3.88%**	**7.30%**	**5.23%**	**6.57%**	**3.78%**	**2.26%**	**4.65%**	**1.46%**	**2.02%**	**4.42%**

*Plan years for these counties are not calendar year. Contributions shown for these counties are for the first 6 months of the calendar year and last 6 months of the previous year.

2016 10-County Survey

Process

The City Charter specifies the City & County of San Francisco survey the ten 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 City is obligated by Charter to contribute the 10-County Survey amount toward the cost of employees' medical benefits.

The information gathered from the 10-County Survey is used to compute an average increase in employer contributions for each county. HSS then averages these averages to arrive at the 10-County Survey amount. To put the county contribution amounts into context, HSS also collects information on premium increases and plan design data such as employee co-pays and contributions toward physician office visits, emergency room care, hospital stays, prescriptions and deductibles.

At the April 12, 2012 Health Service Board meeting, the Board approved the 10-County Survey Calendar Year Change Rule. This rule adjusts for gaps in 10-County data, by projecting a six-month overlap when data is not available from a surveyed county. Using this rule, a county's employer contribution for employee-only coverage is projected. The county's 10-County result for the previous year is, in most cases, trended forward six months, based on the county's average annual increase for the preceding three years.

There were no major changes to the type of plan design data collected for the 2017 plan year. Additionally, plan design data for CalPERS and HSS is included for informational purposes only. CalPERS and HSS data is not included in the 10-County Survey.

Results and Observations

The average monthly contribution of $604.84 for plan year 2017 is 4.42% above $579.24, the 10-County average for plan year 2016. All counties had a change in contribution.

10-County Survey Calendar Year Change Rule: Example Calculation Based on Los Angeles County

For the 2016 calendar year, the average employer premium contribution for Los Angeles County medical plans is $627.40. Per the Calendar Year Change Rule, this $627.40 is projected forward six months, using Los Angeles County's three year premium increase trend of 6.8%. This results in the average employer premium contribution calculated at $648.37 for Los Angeles County. The March 2016 10-County Survey will be applied to Health Service System rate calculations for plan year 2017.

Methodology Assessment

Historically, the 10-County methodology has been evaluated and prior year projections have been compared to actuals. For Calendar Year 2016, there are a few instances where there are significant differences between prior projections and actuals. This is driven by changes in premiums and employer contributions. However, the overall assessment is less than 1.9% from what was calculated ($590.07 actual vs. $579.24 estimated).

File #160747
C: BOS

Wong, Linda (BOS)

From:	Board of Supervisors, (BOS)
Sent:	Friday, July 22, 2016 3:16 PM
To:	BOS-Supervisors; Wong, Linda (BOS)
Subject:	File 160747 FW: memo to President Breed re: HSS Rates & Benefits item on July 26 Board Agenda
Attachments:	Breed 2017 Rates and Beneftis Overview full BoS explanation.docx

From: Dodd, Catherine (HSS)
Sent: Friday, July 22, 2016 1:43 PM
To: Board of Supervisors, (BOS) <board.of.supervisors@sfgov.org>
Subject: memo to President Breed re: HSS Rates & Benefits item on July 26 Board Agenda

Dear Supervisor Breed,
Please find attached a summary of the HSS item on next Tuesday's board calendar. The Budget and Finance Committee passed it out with a yes recommendation. There were some concerns raised by some retirees which are addressed at the end of the attached summary.
Thank you for your support.

Warmest Regards,
Catherine Dodd PhD, RN
Director, SF Health Service System
atherine.dodd@sfgov.org
Seretha Gallaread
Administrative Services Manager
415-554-0660

HEALTH SERVICE SYSTEM
CITY & COUNTY OF SAN FRANCISCO

Memorandum

DATE: July 22, 2016

TO: Supervisor London Breed
President of the San Francisco Board of Supervisors

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

RE: Board of Supervisors Consideration of 2017 Rates and Benefits: Overview

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The 2017 Health Service System Rates and Benefits package, as approved by the Health Service Board (HSB), and passed at the July 20 Budget and Finance Committee meeting is on calendar for first reading at the July 26, 2016 Board of Supervisors meeting. The second reading will be on Aug 2, 2016.

In order to facilitate your review, and to help your staff respond to calls and emails with confusing information which you may be receiving from Medicare eligible retirees, the following summarizes the major changes in both benefits and rates for actives, early retirees and Medicare eligible retirees. The 2017 premiums are compared to the current 2016 rates.

I will make myself or our Deputy Director Mitchell Griggs available by phone or in person before the Board of Supervisors' meeting. Please call Seretha Gallaread to schedule meeting 415-554-1727 or me directly: 415-554-1703.

Benefit changes for 2017

Addition of medical second opinion service. It is estimated that 44% of medical diagnosis are incorrect adding both a financial and human cost. Beginning in 2017, all members and their dependents will be able to request a second medical opinion from "Best Doctors" an organization with hundreds of nationally renowned experts with extensive and specific expertise in particular areas. This review will help address the limited second option currently offered to the 90% of HSS members who are enrolled in an HMO plan. The rate is $1.40 per member per month. An evaluation of the benefit will include avoided costs due to misdiagnoses and incorrect treatment plans.

Kaiser Permanente (Kaiser) is adding a new acupuncture benefit in 2017. Kaiser is also adding a third tier of copays for specialty drugs with the exception of HIV drugs. The

drug co-pays tiers are now the same as Blue Shield. This change resulted in no premium change.

Vision

Vision Services for actives, early retirees, and retirees are provided by VSP. For 2017, VSP proposed a 2% reduction in premiums and a rate guarantee through December 31, 2019. Computer Vision Care (VDT) benefits will continue to be covered for certain union groups.

Dental

Three dental plans will continue to be offered: Delta Dental PPO, Delta Care USA, and Pacific Union Dental. The rates for Delta Dental for actives and early retirees will increase by 0.8%. The premiums for Delta Dental PPO for retirees, DeltaCare plans for actives and retirees and Pacific Union plans for actives and retirees will not change from 2016 rates. Additional benefits were added to the latter plans.

Actives and Early Retirees

Blue Shield of California (Blue Shield), Kaiser Permanente (Kaiser) and United Health Care (UHC City Plan) will continue to provide medical benefits for actives and early retirees.

Blue Shield

The Blue Shield (Flex-funded) premium increase for actives and early retirees is 3.97%. When Best Doctors, Vision and the charge for the Healthcare Sustainability Fund are taken into account the premiums are increasing by 4.26%. There are no benefit changes.

Kaiser

Kaiser rates are currently under a two-year guarantee that expires December 31, 2016. The 2017 premiums increase is 4.79%. When Best Doctors, Vision and the charge for the Healthcare Sustainability Fund are taken into account the premiums are increasing by approximately 5%.

UHC City Plan

In June of 2016, the HSB used additional funding from the stabilization reserve to decrease the active and early retiree premiums because the initial rates for 2017 were calculated at 48.8%. The Health Service Board applied additional funding from the rate stabilization reserve to further buy down the premium increase to 12.96% with funds

made available from the transition to fully funding Medicare retirees in City Plan (UHC). When Best Doctors, Vision and the charge for the Healthcare Sustainability Fund are taken into account the premiums are increasing by approximately 13.18%.

Medicare Retirees

Medicare retirees will have two plan choices in 2017: Kaiser Permanente Senior Advantage and the 'New City Plan PPO' (UHC Medicare Advantage PPO). The Blue Shield Medicare Advantage and Coordination of Benefits Plans are being eliminated because of extraordinarily high renewal rate proposals and because many members have had difficulty with the Blue Shield plans. Retirees currently in Blue Shield will need to choose between Kaiser Permanente Senior Advantage and the 'New City Plan PPO' (UHC Medicare Advantage PPO) plans in 2017.

Kaiser

The Kaiser Medicare Advantage Prescription Drug Retiree rates increase by 8.02% in 2017 primarily due to an adjustment resulting from CMS rates. When Best Doctors, Vision and the charge for the Healthcare Sustainability Fund are taken into account the premiums are increasing 8.76%. A new Wellness program is added called Silver & Fit Exercise and Healthy Aging Program is added.

UHC 'New City Plan'

The Health Service Board (HSB) made changes in the plan options for 2017 Medicare retirees not enrolled in Kaiser. These plan changes are to keep the Medicare plans affordable. Blue Shield's proposed increase for 2017 was 10.2% (with substantial decreased choices in the pharmacy formulary) and City Plan's increase was 29%.

The overall increase in 2017 premium rates for Blue Shield, Kaiser, City Plan and the United Health Care National PPO would have totaled 13.8%at a cost of $14.9 million. In the view of the HSB, a different health plan alternative was required. As a result of adopting the 'New City Plan' the increase is reduced to 4.5% at a cost of $5.3 million. The savings to the City is $9.6 million and nearly $1million to retirees in premiums alone.

The change the Board adopted eliminates the Blue Shield plan for Medicare retirees (early retirees will be able to stay in Blue Shield until they turn 65 - provisions will be made for spouses who are over and under 65). Retirees will be able to keep their physicians because all physicians who accept Medicare are paid covered by United Health Care.

The Board also voted to change the funding of City Plan PPO for Medicare retirees. City Plan is currently administered by United HealthCare (UHC) and funded directly by

the employers (City and County, Unified School District, City College and the Courts. The "New City Plan PPO" will be funded by UHC as a Medicare Advantage PPO. This is an insurance financing decision, it will not affect plan benefits and it will save money for retirees with lower copays and no deductibles. It also saves the City over $8 million.

Retirees living outside the Bay Area or California will have a greater choice physicians because both currently, Blue Shield and the current City Plan have "networks" from which to select physicians. (The current City Plan allows members to go "out of Network" if they pay 50% of the cost). The 'New City Plan' UHC PPO includes any physician or hospital in the United States that accepts Medicare. If retirees are having difficulty finding a physician, UHC will assist in outreach and making initial appointments. This is especially helpful for retirees relocating to rural areas. Retirees will continue the health coverage they now have without disruption. They will have lower or simple co-pays rather than cost sharing based on percentages. They will also have no deductibles, no balance billing, no referrals required to see specialists, and additional benefits like Silver Sneakers, and decreased cost of diabetic supplies.

City Plan retiree couples with one Medicare member and one pre-Medicare member would remain in City Plan just as they do today except the Medicare member would have copays instead of coinsurance, (no cost increase) no provider changes and a broader network nationwide. For the current Blue Shield couples in the same circumstances, the pre-sixty five retiree or spouse will stay in Blue Shield until they reach 65 and then move to the "New City Plan" or both could move to Kaiser Permanente Senior Advantage.

Retiree concerns:

The Health Service Board received 35 emails from retirees and testimony from seven individuals at the June 21st meeting (some testified and emailed) expressing concern about these changes. The majority were from retirees concerned that somehow the new financing of the City Plan PPO (through the UHC Medicare Advantage Plan (MAPD)) would mean they would lose their physician. Some Blue Shield retirees expressed the same concern. The Health Service Board president responded to every email and testimony by explaining that they will not lose their physician or hospital because the "New City Plan" United Health Care MAPD PPO pays any physician or hospital that accepts Medicare nationwide.

Some members just did not want change and some members believed that the decision was made to hastily without retiree input. It was explained that the rising cost of retiree coverage has been discussed by the Health Service Board for some years. In addition, in 2016 when the UHC MAPD PPO was introduced as a lower cost option, members who chose that option have been very satisfied.

A couple of members said this vote was rushed through. This concept was first discussed last year and the HSB agreed to add this option for the current plan year to

see if it was feasible. So far there have been only a couple of complaints that were easily resolved. This is not a new idea. The hearing for this plan change (eliminating Blue Shield for Medicare retirees), and for changing the financing of City Plan, was properly noticed with more than 72 hours pursuant to meeting requirements. The Health Service Board is made up of three elected members elected from the HSS membership (currently two retirees and one active member) and four appointees (1-BOS: Sup Farrell, 1-Controller: Randolph Scott, 1 MD appointed by the Mayor: Dr. Follansbee and 1 expert in health care financing: Gregg Sass – former CCSF DPH CFO retired). These members are elected and appointed to represent the interests of all the retirees and they took the decision seriously.

The HSB vote was 4:2 in favor of adopting the changes which broaden the network of physicians and hospitals for Medicare retirees to choose from and which lowers costs. Two retirees (elected) opposed, one active elected voted in favor and the three appointed members voted in favor (the fourth appointed was absent).

At the July 20 Budget and Finance Committee meeting concerns were expressed that retirees living outside of the country would lose their City Plan coverage. This is not true. Retirees living outside the country must give up their Medicare coverage and will be enrolled in the non-Medicare City Plan coverage and pay out of network co-insurance just as they do today.

Aon

June 28, 2016

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, 2017 to December 31, 2017 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 City and County of San Francisco Health Service System (HSS) with regard to the completed rates and contribution setting process for the plan year from January 1, 2017 to December 31, 2017. This process was concluded on June 21, 2016 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 four members of the Health Service Board during their meeting on June 21, 2016. 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 funded premiums and administrative fees agree with HSS' vendors' final rates and represent a fair price given the services provided, and;
- The premium equivalents set for the HSS self-funded and flex-funded programs: City Plan (UHC), 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 2016 and 2017, 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.

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 is 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 was due to employees by March 31, 2016 (a one-time extension was provided from January 31). 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 was due to the IRS by June 30, 2016 (a one-time extension was provided from March 31). HSS successfully met this requirement by sending 51,000 IRS forms to employees and electronically reporting to the IRS.

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

In the PPACA legislation two direct fees and one Health Insurance Tax were created. In 2017 only the Patient Centered Outcomes Research Institute (PCORI) Fee is required to be paid and it has been factored into the calculation of medical premium rates and premium equivalents for the 2017 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). Below, and continued onto the next page, please find a brief explanation of these fees:

- Health Insurance Tax (HIT): This tax impacts all fully funded or flex-funded plans including vision and dental plans that HSS offers. The Consolidated Appropriations Act of 2016, Title II, § 201,

Moratorium on Annual Fee on Health Insurance Providers, suspends collection of the health insurance provider fee for the 2017 calendar year. Thus, health insurance issuers are not required to pay these fees for 2017. (See Table 1 a. and Table 1b.)

- 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, $2.25 per enrollee per year in 2016 and is expected to remain unchanged at $2.25 per enrollee per year in 2017. (See Table 1 a. and Table 1 b.) 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 was assessed to all participants where Medicare is not the primary payer. This fee is 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 for HSS (all four employers) on medical premiums/premium equivalents are $770.7 million. Of this total, the legislative fees and taxes are $0.28 million or 0.04% of total expenditure. The following tables summarize the estimated aggregate cost of each of these legislative fees for 2017 for all four employers served by the Trust (Table 1 a) and CCSF only (Table 1b).

Table 1a

2017 Legislative Fees ($ millions) All Four Employers

Fee	City Health Plan (UHC)	Kaiser	Blue Shield	Dental	VSP	Total
HIT	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
PCORI	$0.02	$0.15	$0.11	N/A	N/A	$0.28
Transitional Reinsurance	$0.00	$0.00	$0.00	N/A	N/A	$0.00
Total	**$0.02**	**$0.15**	**$0.11**	**$0.00**	**$0.00**	**$0.28**

Table 1b 2017 Legislative Fees ($ millions) CCSF Only						
Fee	City Health Plan (UHC)	Kaiser	Blue Shield	Dental	VSP	Total
HIT	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
PCORI	$0.02	$0.11	$0.09	N/A	N/A	$0.22
Transitional Reinsurance	$0.00	$0.00	$0.00	N/A	N/A	$0.00
Total	**$0.02**	**$0.11**	**$0.09**	$0.00	**$0.00**	**$0.22**

Contributions under the 10-County Survey

According to the City Charter Section A8.428, the employer 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 CCSF collective bargaining process, the 10-County Survey (Survey) was eliminated for the majority of the CCSF unions in the calculation of premium contributions for active employees in exchange for a percentage-based employee premium contribution. The Survey is still used as a basis for calculating all retiree premium contributions. For the 2017 plan year, the Survey, based on 2016 rates, determined that the average monthly contribution increased 4.42% from $579.24 to $604.84. Exhibit 1 presents the individual county responses from the Survey.

Year-Over-Year Health Plan Cost Comparison for All Four Employers

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

Table 2 January 1, 2017 to December 31, 2017 Aggregate Medical Cost ($ millions)			
	Aggregate Member Contributions (a)	Aggregate Employer Contributions (b)	Aggregate Plan Cost (a + b)
Current Rates	**$81.3**	**$654.0**	**$735.3**
Final Renewal Rates	**$85.6**	**$685.1**	**$770.7**
$ Difference	$4.3	$31.1	$35.4
% Difference	5.29%	4.76%	4.81%

The previous table illustrates an increase in aggregate plan costs totaling $35.4 million, or 4.81%, for the three medical plans (including vision cost, Best Doctor's and HSS Healthcare Sustainability Fund expense) for the 2017 plan year. This increase in costs will be split 12%/88% between the members and employers with member contributions increasing $4.3 million and employer contributions increasing $31.1 million. These changes are based on current June 2016 enrollment.

Current City and County (CCSF) Contribution Strategy

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

1) 93/93/83 Contribution Model:

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

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

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

2) 100/96/83 Contribution Model:

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

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

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

shall be capped at eighty-three percent (83%) of the Employee Plus Two or More premium/premium equivalent of the second-highest-cost plan.

Since the majority of CCSF employees fall into the two contribution models, Aon produced two sets of rate cards, both approved by the HSB for plan year 2017. 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 for All Four Employers

Consistent with the 2016 plan year, two HMO plans will be offered to HSS members for plan year 2017. These plans are offered by Kaiser Permanente and Blue Shield of California.

Plan Design Changes for HMOs

Plan design changes were adopted by the Rates and Benefits Committee and the HSB as follows:

Kaiser Permanente (Fully Funded)
The two-year rate guarantee by Kaiser Permanent ends December 31, 2016. The final negotiated rate change for Kaiser Permanente active, early retiree, Medicare retirees is an overall increase of 5.46% for 2017 through December 31, 2017. This results in an overall estimated increase of $19.4 million annually for all four employers based on June 2016 membership of which $14.7 million is attributed to CCSF and $4.7 million is attributed to the other employer groups (e.g., CRT, USD, and CCD).

The aggregate cost for Kaiser Permanente for the 2017 plan year is projected at $375.3 million, with $39.7 million in member contributions and $335.6 million in employer contributions. Table 3 (page 11) provides an overview of annualized costs.

The HSB will add an acupuncture benefit for the 2017 plan year for the Kaiser Permanente plan. A third tier of copays was added for specialty drugs with the exception of HIV drugs which resulted in no premium change.

Blue Shield of California (Flex-funded)
On January 1, 2013, the funding arrangement for actives and retirees without Medicare switched from fully funded to flex-funded. Claims experience highlighted by increased cost for specialty pharmacy led to a required increase of 2.58% for the premium equivalents for actives and early retirees for plan year 2017. The HSB adopted no plan design changes for the active and early retiree Blue Shield of California plan.

At the June 21, 2016 HSB meeting the HSB adopted the proposal to eliminate the Blue Shield of California 65 Plus MAPD and Blue Shield of California Access+ (COB) plan due to a 10.2% proposed rate increase for Medicare retirees and adopt the UnitedHealthcare fully funded Medicare Advantage PPO which is branded as the "New City Plan". This transition to the UHC program reduced the cost for retirees currently on Blue Shield of California Medicare plans by 11.1%.

The aggregate cost for all four employers in the Blue Shield of California HMO for the 2017 plan year is projected at $344.3 million, with $39.6 million in member contributions and $304.7 million in employer contributions based on June 2016 membership. This results in an overall estimated increase of $8.7 million annually for all four employers based on June 2016 membership of which $6.6 million is attributed to CCSF and $2.1 million is attributed to the other employer groups (e.g., CRT, USD, and CCD). Table 3 (page 11) provides an overview of annualized costs. The contribution models for the HMO active and retired members are summarized in exhibits 2a-2b and 3a-3c.

Rates, Contributions, and Benefits for the Self-Funded City Plan (UHC) for All Four Employers

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 provided a retrospective analysis of historical rates and experience to examine the actual cost trends evident in the City 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 2017 plan year.

No plan design changes were adopted by the Rates and Benefits Committee and the HSB.

The final monthly premium equivalents, with no plan design changes, result in an overall increase of 16.65%. Included in this increase is a one-time buy-down of $3.79 million applied to the active employees and early retirees.

The UHC administration fee increased 3% from 2016 to 2017.

Rates, Contributions, and Benefits for Retirees in City Plan (UHC) for All Four Employers

As of January 1, 2017 retirees will be covered under the UnitedHealthcare fully funded Medicare Advantage PPO which is branded as the "New City Plan".

At the end of 2015, over $0.4 million of underwriting losses were placed into the City Plan PPO Rate Stabilization Reserve per the Self-Funded Plans' Stabilization Policy. This loss decreased the overall amount in the reserve to $11.4 million as presented at the February 11, 2016 Health Service Board meeting. Per the Health Service Board's Self-Funded Plans' Stabilization Policy, one-third of the amount in the stabilization reserve (or $3.8 million) was spread across all membership categories (actives, early retirees and Medicare retirees) to lower the City Plan premium equivalents.

Per the adoption of the UnitedHealthcare fully funded "New City Plan" at the June 21, 2016 Board meeting, the Board elected to support the allocation of the $3.8 million to the self-funded active employees ($2.0 million of this amount comes from the Medicare retirees per the policy) and early retirees (the retirees, per the policy, no longer receive the allocation under a fully funded status) and

to apply an additional $3.8 million as a one-time buy-down to the active employees and early retirees for a total of $7.6 million. This transition to the UHC program reduced cost for UHC Medicare retirees by 7.7% from the initially projected 29.0% for 2017. This saved approximately $2.53 million for all four employers of which $1.92 is attributed to CCSF. Please see exhibits 4a and 4b to review the impact to active employee and early retiree contributions for all four employers.

Changes in monthly premium equivalents for the City Plan are also 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 Heath Plan for the 2017 plan year is projected at $51.0 million, with $6.2 million in member contributions and $44.8 million in employer contributions. This results in an overall estimated increase of $7.3 million annually for all four employers based on June 2016 enrollment of which $5.5 million is attributed to CCSF and $1.8 million is attributed to the other employer groups (e.g., CRT, USD, and CCD). Table 3 (page 11) provides an overview of annualized costs.

Changes in employee and retiree contributions for City Plan (UHC) are summarized in Exhibits 4a and 4b. These contributions were determined in accordance with the City Charter which include the most recent 10-County Survey result of $604.84, if applicable, and adjusts for the 93/93/83 and 100/96/83 contribution models.

Rates and Benefits for the Vision Plan for All Four Employers

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 funded plan. As of January 1, 2017, VSP vision plan premiums will decrease 2% from 2016 levels and are guaranteed through December 31, 2019. Additionally, the VSP's Acute EyeCare (AEC) plan will be sunset and the plan will move to VSP's Primary EyeCare (PEC) plan. This plan is provided at a two percent (2%) premium reduction compared to the current AEC plan and offers 43 additional covered services. The aggregate cost for the VSP vision plan for the 2017 plan year is projected at $5.0 million. This results in an overall estimated decrease of $0.1 million annually for all four employers based on June 2016 enrollment of which $0.07 million is attributed to CCSF and $0.03 million is attributed to the other employer groups (e.g., CRT, USD, and CCD). VSP vision plan costs for all four employers are summarized in Exhibit 5.

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

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 2017 plan year.

The aggregate premium equivalent for the self-funded Delta Dental PPO plan for active employees shows a 0.8% increase for plan year 2017.

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 funded. The fully funded premiums for the Delta Dental PPO plan for retirees accepted a six percent (6%) premium reduction from 2015 for the plan year 2017. This reduction includes the coverage increase for a diagnostic and preventive care fee waiver. The fully funded 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 funded premiums for the Pacific Union plans were given a rate pass through December 31, 2018.

For the 2017 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 and Delta Care USA dental plans for actives and retirees, and Pacific Union Dental plans for actives and retirees remain unchanged from the 2016 plan year. Pursuant to the Health Service Board's Self-Funded Plans' Stabilization Policy, a claims stabilization amount $2.4 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 6, 7, and 8 respectively.

The aggregate dental plan cost for actives for the 2017 plan year is projected at $47.5 million with $3.6 million in member contributions and $43.9 million in employer contributions. This results in an overall estimated increase of $0.4 million annually for all four employers based on June 2016 enrollment of which $0.3 million is attributed to CCSF and $0.1 million is attributed to the other employer groups (e.g., CRT, USD, and CCD). There is a slight increase in cost to the City for dental care. Table 3 provides an overview of annualized costs.

Life and Long Term Disability (LTD) Insurance for CCSF Actives Only

Basic life insurance (employer paid) premiums remain unchanged and are guaranteed through December 31, 2019. Beginning in 2017 supplemental life insurance (employee paid) premiums will be

split into tobacco and non-tobacco rates based on each individual's tobacco use status. Premium rates for non-tobacco users will decrease from current premiums by 7.5% on average (varies by age band) while premium for tobacco users will increase by 1.2% on average (varies by age band). In addition, in 2017 supplemental life insurance will be offered as a voluntary benefit to CCSF employees.

Premiums for the long-term disability plan will decrease 7.1% from the 2016 rates and are guaranteed through December 31, 2019. Premiums were decreased based on favorable claims experience under the plan. The increase is due to membership and salary increases.

The aggregate life and LTD plan cost for the 2017 plan year is projected at $10.3 million, with $2.5 million in member contributions and $7.8 million in employer contributions. Annualized cost comparisons are summarized in Exhibit 9.

Second Opinion Benefit for All Four Employers and All Retirees

It is estimated that 44% of medical diagnosis are incorrect adding both a financial and human cost. Over 90% of HSS members are enrolled in an HMO with very limited second opinion options. The HSB on April 14, 2016 approved an additional benefit for medical second opinions at a rate of $1.40 per member per month. For many complex and/or rare health diagnoses it is beneficial to obtain a second opinion from a nationally known expert with extensive experience and subspecialty expertise for the particular area. The review is to ensure that the diagnosis and treatment plan is appropriate and medical care is delivered in the most cost-effective and least invasive way based on clinical evidence. Members may call the second opinion vendor or they may be identified through claims analysis by the second opinion vendor.

Summary of Projected 2017 Plan Year Costs

Table 3 is a summary of how projected 2017 aggregate HSS plan costs are distributed across the different plans that are available to active employees and retirees as compared to 2016. 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)					
	Aggregate Member Contributions (a)	Aggregate Employer Contributions (b)	Aggregate Plan Cost (a + b)	Member Contributions as a % of Aggregate Costs	Employer Contributions as a % of Aggregate Costs
Kaiser HMO **	**$39.7**	**$335.6**	**$375.3**	**10.58%**	**89.42%**
$ Increase	$2.0	$17.4	$19.4		
% Increase	5.37%	5.48%	5.46%		
Blue Shield HMO **	**$39.6**	**$304.7**	**$344.3**	**11.51%**	**88.49%**
$ Increase	$1.2	$7.5	$8.7		
% Increase	2.99%	2.53%	2.58%		
City Plan **	**$6.2**	**$44.8**	**$51.0**	**12.21%**	**87.79%**
$ Increase	$1.1	$6.2	$7.3		
% Increase	22.10%	15.93%	16.65%		
Dental ***	**$3.6**	**$43.9**	**$47.5**	**7.56%**	**92.44%**
$ Increase	$0.0	$0.4	$0.4		
% Increase	0.00%	0.83%	0.76%		
LTD	**$0.0**	**$6.9**	**$6.9**	**0.00%**	**100.00%**
$ Increase	$0.0	$0.2	$0.2		
% Increase	0.00%	2.54%	2.54%		
Life	**$2.5**	**$0.9**	**$3.4**	**72.67%**	**27.33%**
$ Increase	$2.3	$0.0	$2.3		
% Increase	1036.36%	4.44%	207.14%		
Total	**$91.6**	**$736.8**	**$828.5**	**11.06%**	**88.94%**
$ Increase	$6.6	$31.7	$38.2		
% Increase	7.73%	4.49%	4.84%		

* *All calculations are based on June 2016 enrollment, figures vary due to rounding*

** *Includes $1.40 per employee per month (PEPM) for Best Doctors a second opinion vendor and $3.00 PEPM for the Health Care Sustainability Fund*

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

This year's projected aggregate cost increase of 4.84% compares favorably with available benchmark information. The "2016 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 validates all of the findings presented within this report. Aon would be pleased to answer any questions or provide clarification about the information included in this letter to any interested parties.

Sincerely,

Anil P Kochhar

Anil Kochhar, ASA, MAAA
Vice President, Aon

cc: President and Members of the Health Service Board
Catherine Dodd, San Francisco Health Service System

San Francisco Health Service System
Board of Supervisors

10-County Survey Results

Rates and Benefits Decisions

Calendar Year 2017

June 27, 2016

Prepared by:
Aon | Aon Hewitt | Health & Benefits

Empower Results®

10-County Survey Results

Exhibit 1

Rank	County	CY 2016	CY 2017	% Change
1	Los Angeles	$619.87	$648.37	4.60%
2	San Diego	$477.99	$507.13	6.10%
3	Orange	$525.51	$517.98	-1.43%
4	Riverside	$616.96	$652.09	5.69%
5	San Bernardino	$421.18	$417.04	-0.98%
6	Santa Clara	$785.13	$917.21	16.82%
7	Alameda	$684.14	$687.86	0.54%
8	Sacramento	$549.40	$574.78	4.62%
9	Contra Costa	$623.46	$637.99	2.33%
10	Fresno	$488.79	$488.00	-0.16%
10-County Average		**$579.24**	**$604.84**	**4.42%**

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Kaiser Permanente HMO: Final Active / Early Retiree / Medicare Monthly Contributions for Calendar Year 2017

Exhibit 2a — 93/93/83 Contribution Method *

		Active			Early Retiree			MAPD			
		EE	EE + 1	EE + 2	RET	RET + 1	RET + 2	RET	RET + 1	RET + 2 All Medicare	RET + 2 Other
Employee/ Retiree Contributions	Plan Year 2016	$38.78	$77.42	$265.91	$0.00	$275.99	$734.14	$0.00	$159.48	$477.74	$617.63
	Plan Year 2017	$40.78	$81.25	$278.90	$0.00	$289.08	$768.95	$0.00	$172.36	$516.40	$652.23
	$ Increase	*+$2.00*	*+$3.83*	*+$12.99*	*+$0.00*	*+$13.09*	*+$34.81*	*+$0.00*	*+$12.88*	*+$38.66*	*+$34.60*
	% Increase	*+5.16%*	*+4.95%*	*+4.89%*	—	*+4.74%*	*+4.74%*	—	*+8.08%*	*+8.09%*	*+5.60%*
Employer Contributions	Plan Year 2016	$515.24	$1,028.59	$1,298.25	$1,112.19	$1,388.19	$1,388.19	$320.99	$480.47	$480.47	$480.47
	Plan Year 2017	$541.76	$1,079.45	$1,361.67	$1,167.51	$1,456.59	$1,456.59	$349.11	$521.48	$521.48	$521.48
	$ Increase	*+$26.52*	*+$50.86*	*+$63.42*	*+$55.32*	*+$68.40*	*+$68.40*	*+$28.12*	*+$41.01*	*+$41.01*	*+$41.01*
	% Increase	*+5.15%*	*+4.94%*	*+4.89%*	*+4.97%*	*+4.93%*	*+4.93%*	*+8.76%*	*+8.54%*	*+8.54%*	*+8.54%*
Total Rate	Plan Year 2016	$554.02	$1,106.01	$1,564.16	$1,112.19	$1,664.18	$2,122.33	$320.99	$639.95	$958.21	$1,098.10
	Plan Year 2017	$582.54	$1,160.70	$1,640.57	$1,167.51	$1,745.67	$2,225.54	$349.11	$693.84	$1,037.88	$1,173.71
	$ Increase	*+$28.52*	*+$54.69*	*+$76.41*	*+$55.32*	*+$81.49*	*+$103.21*	*+$28.12*	*+$53.89*	*+$79.67*	*+$75.61*
	% Increase	*+5.15%*	*+4.94%*	*+4.89%*	*+4.97%*	*+4.90%*	*+4.86%*	*+8.76%*	*+8.42%*	*+8.31%*	*+6.89%*

*** NOTE:**

- Includes $1.40 PEPM for Best Doctors a second opinion vendor and $3.00 for the Health Care Sustainability Fund.
- **Additional footnotes are defined on page 15.**

Kaiser Permanente HMO: Final Active / Early Retiree / Medicare Monthly Contributions for Calendar Year 2017

Exhibit 2b — 100/96/83 Contribution Method *

		Active			Early Retiree			MAPD			
		EE	EE + 1	EE + 2	RET	RET + 1	RET + 2	RET	RET + 1	RET + 2 All Medicare	RET + 2 Other
Employee/ Retiree Contributions	Plan Year 2016	$0.00	$44.24	$265.91	$0.00	$275.99	$734.14	$0.00	$159.48	$477.74	$617.63
	Plan Year 2017	$0.00	$46.43	$278.90	$0.00	$289.08	$768.95	$0.00	$172.36	$516.40	$652.23
	$ Increase	*+$0.00*	*+$2.19*	*+$12.99*	*+$0.00*	*+$13.09*	*+$34.81*	*+$0.00*	*+$12.88*	*+$38.66*	*+$34.60*
	% Increase	—	*+4.95%*	*+4.89%*	—	*+4.74%*	*+4.74%*	—	*+8.08%*	*+8.09%*	*+5.60%*
Employer Contributions	Plan Year 2016	$554.02	$1,061.77	$1,298.25	$1,112.19	$1,388.19	$1,388.19	$320.99	$480.47	$480.47	$480.47
	Plan Year 2017	$582.54	$1,114.27	$1,361.67	$1,167.51	$1,456.59	$1,456.59	$349.11	$521.48	$521.48	$521.48
	$ Increase	*+$28.52*	*+$52.50*	*+$63.42*	*+$55.32*	*+$68.40*	*+$68.40*	*+$28.12*	*+$41.01*	*+$41.01*	*+$41.01*
	% Increase	*+5.15%*	*+4.94%*	*+4.89%*	*+4.97%*	*+4.93%*	*+4.93%*	*+8.76%*	*+8.54%*	*+8.54%*	*+8.54%*
Total Rate	Plan Year 2016	$554.02	$1,106.01	$1,564.16	$1,112.19	$1,664.18	$2,122.33	$320.99	$639.95	$958.21	$1,098.10
	Plan Year 2017	$582.54	$1,160.70	$1,640.57	$1,167.51	$1,745.67	$2,225.54	$349.11	$693.84	$1,037.88	$1,173.71
	$ Increase	*+$28.52*	*+$54.69*	*+$76.41*	*+$55.32*	*+$81.49*	*+$103.21*	*+$28.12*	*+$53.89*	*+$79.67*	*+$75.61*
	% Increase	*+5.15%*	*+4.94%*	*+4.89%*	*+4.97%*	*+4.90%*	*+4.86%*	*+8.76%*	*+8.42%*	*+8.31%*	*+6.89%*

*** NOTE:**

- Includes $1.40 PEPM for Best Doctors a second opinion vendor and $3.00 for the Health Care Sustainability Fund.
- **Additional footnotes are defined on page 16.**

Blue Shield of California HMO: Final Active / Early Retiree Monthly Contributions for Calendar Year 2017

Exhibit 3a — 93/93/83 Contribution Method *

		Active			Early Retiree		
		EE	EE + 1	EE + 2	RET	RET + 1	RET + 2
Employee / Retiree Contributions	Plan Year 2016	$50.51	$100.87	$346.50	$71.14	$445.00	$1,042.17
	Plan Year 2017	$52.66	$105.01	$360.53	$73.70	$462.50	$1,083.16
	$ Increase	*+$2.15*	*+$4.14*	*+$14.03*	*+$2.56*	*+$17.50*	*+$40.99*
	% Increase	*+4.26%*	*+4.10%*	*+4.05%*	*+3.60%*	*+3.93%*	*+3.93%*
Employer Contributions	Plan Year 2016	$671.02	$1,340.20	$1,691.74	$1,593.25	$1,967.11	$1,967.11
	Plan Year 2017	$699.59	$1,395.08	$1,760.23	$1,659.72	$2,048.51	$2,048.52
	$ Increase	*+$28.57*	*+$54.88*	*+$68.49*	*+$66.47*	*+$81.40*	*+$81.41*
	% Increase	*+4.26%*	*+4.09%*	*+4.05%*	*+4.17%*	*+4.14%*	*+4.14%*
Total Rate	Plan Year 2016	$721.53	$1,441.07	$2,038.24	$1,664.39	$2,412.11	$3,009.28
	Plan Year 2017	$752.25	$1,500.09	$2,120.76	$1,733.42	$2,511.01	$3,131.68
	$ Increase	*+$30.72*	*+$59.02*	*+$82.52*	*+$69.03*	*+$98.90*	*+$122.40*
	% Increase	*+4.26%*	*+4.10%*	*+4.05%*	*+4.15%*	*+4.10%*	*+4.07%*

*** NOTE:**

- The 2017 Medicare cost for Blue Shield members are based on the UHC retiree replacement programs premiums adopted at the June 21, 2016 Health Service Board meeting.
- Includes $1.40 PEPM for Best Doctors a second opinion vendor and $3.00 for the Health Care Sustainability Fund.
- **Additional footnotes are defined on page 15.**

Blue Shield of California HMO: Final Active / Early Retiree Monthly Contributions for Calendar Year 2017

Exhibit 3b — 100/96/83 Contribution Method *

		Active			Early Retiree		
		EE	EE + 1	EE + 2	RET	RET + 1	RET + 2
Employee / Retiree Contributions	Plan Year 2016	$0.00	$57.64	$346.50	$71.14	$445.00	$1,042.17
	Plan Year 2017	$0.00	$60.00	$360.53	$73.70	$462.50	$1,083.16
	$ Increase	*+$0.00*	*+$2.36*	*+$14.03*	*+$2.56*	*+$17.50*	*+$40.99*
	% Increase	—	*+4.09%*	*+4.05%*	*+3.60%*	*+3.93%*	*+3.93%*
Employer Contributions	Plan Year 2016	$721.53	$1,383.43	$1,691.74	$1,593.25	$1,967.11	$1,967.11
	Plan Year 2017	$752.25	$1,440.09	$1,760.23	$1,659.72	$2,048.51	$2,048.52
	$ Increase	*+$30.72*	*+$56.66*	*+$68.49*	*+$66.47*	*+$81.40*	*+$81.41*
	% Increase	*+4.26%*	*+4.10%*	*+4.05%*	*+4.17%*	*+4.14%*	*+4.14%*
Total Rate	Plan Year 2016	$721.53	$1,441.07	$2,038.24	$1,664.39	$2,412.11	$3,009.28
	Plan Year 2017	$752.25	$1,500.09	$2,120.76	$1,733.42	$2,511.01	$3,131.68
	$ Increase	*+$30.72*	*+$59.02*	*+$82.52*	*+$69.03*	*+$98.90*	*+$122.40*
	% Increase	*+4.26%*	*+4.10%*	*+4.05%*	*+4.15%*	*+4.10%*	*+4.07%*

*** NOTE:**

- The 2017 Medicare cost for Blue Shield members are based on the UHC retiree replacement programs premiums adopted at the June 21, 2016 Health Service Board meeting.
- Includes $1.40 PEPM for Best Doctors a second opinion vendor and $3.00 for the Health Care Sustainability Fund.
- **Additional footnotes are defined on page 16.**

City Plan (UHC): Final Active / Early Retiree/Medicare Monthly Contributions for Calendar Year 2017

Exhibit 4a — 93/93/83 Contribution Method *

		Active			Early Retiree			MAPD			
		EE	EE + 1	EE + 2	RET	RET + 1	RET + 2	RET	RET + 1	RET + 2 All Medicare	RET + 2 Other
Employee / Retiree Contributions	Plan Year 2016	$85.65	$144.72	$414.13	$88.71	$540.88	$1,161.83	$0.00	$127.04	$263.96	$747.99
	Plan Year 2017	$102.81	$166.01	$430.34	$98.78	$648.15	$1,426.75	$0.00	$176.19	$527.89	$1,037.15
	$ Increase	*+$17.16*	*+$21.28*	*+$16.21*	*+$10.07*	*+$107.27*	*+$264.92*	*+$0.00*	*+$49.15*	*+$263.93*	*+$289.16*
	% Increase	*+20.04%*	*+14.71%*	*+3.91%*	*+11.35%*	*+19.83%*	*+22.80%*	—	*+38.69%*	*+99.99%*	*+38.66%*
Employer Contributions	Plan Year 2016	$671.02	$1,340.20	$1,691.74	$845.74	$1,297.90	$1,297.90	$280.66	$407.70	$407.70	$407.70
	Plan Year 2017	$699.59	$1,395.08	$1,760.23	$1,043.70	$1,593.07	$1,593.07	$329.18	$477.79	$450.20	$477.79
	$ Increase	*+$28.57*	*+$54.88*	*+$68.49*	*+$197.96*	*+$295.17*	*+$295.17*	*+$48.52*	*+$70.09*	*+$42.50*	*+$70.09*
	% Increase	*+4.26%*	*+4.10%*	*+4.05%*	*+23.41%*	*+22.74%*	*+22.74%*	*+17.29%*	*+17.19%*	*+10.42%*	*+17.19%*
Total Rate	Plan Year 2016	$756.67	$1,484.92	$2,105.87	$934.45	$1,838.78	$2,459.73	$280.66	$534.74	$671.66	$1,155.69
	Plan Year 2017	$802.40	$1,561.09	$2,190.57	$1,142.48	$2,241.22	$3,019.82	$329.18	$653.98	$978.09	$1,514.94
	$ Increase	*+$45.73*	*+$76.17*	*+$84.70*	*+$208.03*	*+$402.44*	*+$560.09*	*+$48.52*	*+$119.24*	*+$306.43*	*+$359.25*
	% Increase	*+6.04%*	*+5.13%*	*+4.02%*	*+22.26%*	*+21.89%*	*+22.77%*	*+17.29%*	*+22.30%*	*+45.62%*	*+31.09%*

* **NOTE:**

- Includes $1.40 PEPM for Best Doctors a second opinion vendor and $3.00 for the Health Care Sustainability Fund.
- **Additional footnotes are defined on page 15.**

City Plan (UHC): Final Active / Early Retiree/Medicare Monthly Contributions for Calendar Year 2017

Exhibit 4b — 100/96/83 Contribution Method *

		Active			Early Retiree			MAPD			
		EE	EE + 1	EE + 2	RET	RET + 1	RET + 2	RET	RET + 1	RET + 2 All Medicare	RET + 2 Other
Employee / Retiree Contributions	Plan Year 2016	$0.00	$101.49	$414.13	$88.71	$540.88	$1,161.83	$0.00	$127.04	$263.96	$747.99
	Plan Year 2017	$0.00	$121.00	$430.34	$98.78	$648.15	$1,426.75	$0.00	$176.19	$527.89	$1,037.15
	$ Increase	*+$0.00*	*+$19.51*	*+$16.21*	*+$10.07*	*+$107.27*	*+$264.92*	*+$0.00*	*+$49.15*	*+$263.93*	*+$289.16*
	% Increase	—	*+19.22%*	*+3.91%*	*+11.35%*	*+19.83%*	*+22.80%*	—	*+38.69%*	*+99.99%*	*+38.66%*
Employer Contributions	Plan Year 2016	$756.67	$1,383.43	$1,691.74	$845.74	$1,297.90	$1,297.90	$280.66	$407.70	$407.70	$407.70
	Plan Year 2017	$802.40	$1,440.09	$1,760.23	$1,043.71	$1,593.07	$1,593.08	$329.18	$477.79	$450.20	$477.79
	$ Increase	*+$45.73*	*+$56.66*	*+$68.49*	*+$197.97*	*+$295.17*	*+$295.18*	*+$48.52*	*+$70.09*	*+$42.50*	*+$70.09*
	% Increase	*+6.04%*	*+4.10%*	*+4.05%*	*+23.41%*	*+22.74%*	*+22.74%*	*+17.29%*	*+17.19%*	*+10.42%*	*+17.19%*
Total Rate	Plan Year 2016	$756.67	$1,484.92	$2,105.87	$934.45	$1,838.78	$2,459.73	$280.66	$534.74	$671.66	$1,155.69
	Plan Year 2017	$802.40	$1,561.09	$2,190.57	$1,142.48	$2,241.22	$3,019.82	$329.18	$653.98	$978.09	$1,514.94
	$ Increase	*+$45.73*	*+$76.17*	*+$84.70*	*+$208.03*	*+$402.44*	*+$560.09*	*+$48.52*	*+$119.24*	*+$306.43*	*+$359.25*
	% Increase	*+6.04%*	*+5.13%*	*+4.02%*	*+22.26%*	*+21.89%*	*+22.77%*	*+17.29%*	*+22.30%*	*+45.62%*	*+31.09%*

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*** NOTE:**

- Includes $1.40 PEPM for Best Doctors a second opinion vendor and $3.00 for the Health Care Sustainability Fund.
- **Additional footnotes are defined on page 16.**

VSP Vision: Final Active / Early Retiree / Medicare Monthly Contributions for Calendar Year 2017

Exhibit 5 — Vision Plan Rates

		Active (Bargained)			Retiree		
		EE	EE+1	EE+2	RET	RET+1	RET+2
Rates	Plan Year 2016	$4.03	$8.08	$11.43	$4.03	$8.08	$11.43
	Plan Year 2017	$3.95	$7.92	$11.20	$3.95	$7.92	$11.20
	% Increase	-1.99%	-1.98%	-2.01%	-1.99%	-1.98%	-2.01%
	$ Increase	($0.08)	($0.16)	($0.23)	($0.08)	($0.16)	($0.23)

Delta Dental PPO: Final Active / Retiree Monthly Contributions for Calendar Year 2017

Exhibit 6 — Dental PPO Plan Rates

		Active (Bargained)			Retiree		
		EE	EE+1	EE+2	RET	RET+1	RET+2
Rates	Plan Year 2016	$64.02	$134.44	$192.05	$42.94	$85.42	$127.49
	Plan Year 2017	$64.51	$135.48	$193.54	$42.94	$85.42	$127.49
	% Increase	0.77%	0.77%	0.78%	0.00%	0.00%	0.00%
	$ Increase	$0.49	$1.04	$1.49	$0.00	$0.00	$0.00

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Delta Care USA: Final Active / Retiree Monthly Contributions for Calendar Year 2017

Exhibit 7 — Delta HMO Plan Rates

		Active (Bargained)			Retiree		
		EE	EE+1	EE+2	RET	RET+1	RET+2
Rates	Plan Year 2016	$26.95	$44.46	$65.76	$32.85	$54.21	$80.19
	Plan Year 2017	$26.95	$44.46	$65.76	$32.85	$54.21	$80.19
	% Increase	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
	$ Increase	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

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Pacific Union Dental: Final Active / Retiree Monthly Contributions for Calendar Year 2017

Exhibit 8 — Dental HMO Plan Rates

		Active (Bargained)			Retiree		
		EE	EE+1	EE+2	RET	RET+1	RET+2
Rates	Plan Year 2016	$27.80	$45.90	$67.86	$16.47	$27.20	$40.22
	Plan Year 2017	$27.80	$45.90	$67.86	$16.47	$27.20	$40.22
	% Increase	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
	$ Increase	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

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Life and Long Term Disability (LTD)
Plan Year 2017 Aggregate Costs

Exhibit 9 — Life and LTD Plan Rates

Plan Type	Plan Year 2016	Plan Year 2017	% Increase	$ Increase
Basic Life	$900,000	$940,000	4%	$40,000
Supplemental Life / Dependent Life	$220,000	$2,500,000	1036%	$2,280,000
Long Term Disability	$6,700,000	$6,870,000	3%	$170,000
Total Annual Estimated Cost	**$7,820,000**	**$10,310,000**	**32%**	**$2,490,000**

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✳ NOTE:

- Beginning in January of 2017, the supplemental life plans will be offered to groups beyond the Municipal Executives Association which will drive up enrollment.

2017 Medicare Advantage PPO (UHC) "New City Plan"

Exhibit 10 — UHC PPO Rate Card

		UHC—PPO			
		RET	RET + 1	RET + 2 All Medicare	RET + 2 Other
Retiree Contributions	Plan Year 2016	$0.00	$154.58	$463.05	$1,045.01
	Plan Year 2017	$0.00	$176.19	$527.89	$1,037.15
	$ Increase	*+$0.00*	*+$21.61*	*+$64.84*	*-$7.86*
	% Increase	—	*+13.98%*	*+14.00%*	*-0.75%*
Retiree Contributions	Plan Year 2016	$311.20	$465.79	$465.79	$465.79
	Plan Year 2017	$329.18	$477.79	$450.20	$477.79
	$ Increase	*+$17.98*	*+$12.00*	*-$15.59*	*+$11.99*
	% Increase	*+5.78%*	*+2.58%*	*-3.35%*	*+2.58%*
Total Rate	Plan Year 2016	$311.20	$620.37	$928.84	$1,510.80
	Plan Year 2017	$329.18	$653.98	$978.09	$1,514.94
	$ Increase	*+$17.98*	*+$33.61*	*+$49.25*	*+$4.14*
	% Increase	*+5.78%*	*+5.42%*	*+5.30%*	*+0.27%*

✳ **NOTE:**

- Includes $1.40 PEPM for Best Doctors a second opinion vendor and $3.00 for the Health Care Sustainability Fund.

Final Monthly Contribution for Calendar Year 2017 Footnotes

Exhibits 2a, 3a, 4a — 93/93/83 Contribution Method

Note—The 93/93/83 Contribution Model defines the following payment structure:

- EE Only: City contributes 93% towards total premium for employees selecting Single tier coverage.
- EE+1: City contributes 93% towards total premium for employees selecting EE+1 tier coverage.
- EE+2: City contributes 83% towards total premium for employees selecting EE+2 tier coverage.
- City contributions are capped at 93%, 93% and 83% of corresponding premium of the second-highest-cost plan for Single, EE+1 and EE+2 tiers respectively.
- Members cover the remaining costs across all tiers.

Final Monthly Contribution for Calendar Year 2017 Footnotes

Exhibits 2b, 3b, 4b — 100/96/83 Contribution Method

Note—The 100/96/83 Contribution Model defines the following payment structure:

- EE Only: City contributes 100% towards total premium for employees selecting Single tier coverage. Members are free of premium charges.
- EE+1: City contributes 96% towards total premium for employees selecting EE+1 tier coverage.
- EE+2: City contributes 83% towards total premium for employees selecting EE+2 tier coverage.
- City contributions are capped at 96% and 83% of corresponding premium of the second-highest-cost plan for EE+1 and EE+2 tiers respectively.
- Members electing EE+1 and EE+2 tiers cover the remaining cost.

MEDICAL PLAN ENROLLMENT

MEMBERSHIP STATUS	CTYPLN	CTYMAP	BLSHLD	BLSHLD ACCESS+	KAISER	WAIVED	DELINQ	TOTAL
ACTIVE Members	782	0	15,783	0	22,831	3,031	165	42,592
NO MEDICARE	782		15,783		22,831	3,031	165	42,592
MEDICARE A								
MEDICARE B								
MEDICARE AB								
RETIRED Members	4,779	953	3,973	3,517	11,037	2,263	7	26,529
NO MEDICARE	496			2,275	2,478	1,637	6	6,892
MEDICARE A				2		8		10
MEDICARE B	40			56	69	2		167
MEDICARE AB	4,193	953	3,973	1,184	8,490	616	1	19,410
NON-COMPLIANT	50							50
SURVIVING SPOUSE	937	71	275	204	1,370	392	3	3,252
NO MEDICARE	58			115	190	221	3	587
MEDICARE A								
MEDICARE B	2			4	2	1		9
MEDICARE AB	873	71	275	85	1,178	170		2,652
NON-COMPLIANT	4							4
COMMISSIONERS	8	0	35	0	31	156	0	230
NO MEDICARE	8		35		31	156		230
MEDICARE A								
MEDICARE B								
MEDICARE AB								
TOTAL MEMBERS	**6,506**	**1,024**	**20,066**	**3,721**	**35,269**	**5,842**	**175**	**72,603**

MEDICAL PLAN ENROLLMENT

MEMBERSHIP STATUS	CTYPLN	CTYMAP	BLSHLD	BLSHLD ACCESS+	KAISER	WAIVED	DELINQ	TOTAL
SPOUSE/DOM PRT DEPENDENTS OF ACTIVE Members	177	0	6,344	0	8,390	0	0	14,911
NO MEDICARE	175		6,316		8,367			14,858
MEDICARE A								
MEDICARE B			1					1
MEDICARE AB	2		27		23			52
SPOUSE/DOM PRT DEPENDENTS OF RETIRED Members	1,343	329	1,238	1,279	3,496	0	0	7,685
NO MEDICARE	233	42	337	795	1,192			2,599
MEDICARE A								
MEDICARE B	5		1	6	11			23
MEDICARE AB	1,104	287	900	478	2,293			5,062
NON-COMPLIANT	1							1
SPOUSE/DOM PRT DEPENDENTS OF SURVIVING SPOUSE	0	0	0	0	0	0	0	
NO MEDICARE								
MEDICARE A								
MEDICARE B								
MEDICARE AB								
NON-COMPLIANT								
SPOUSE/DOM PRT DEPENDENTS OF COMMISSIONERS	4	0	6	0	3	0	0	13
NO MEDICARE	4		6		3			13
MEDICARE A								
MEDICARE B								
MEDICARE AB								

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MEDICAL PLAN ENROLLMENT

MEMBERSHIP STATUS	CTYPLN	CTYMAP	BLSHLD	BLSHLD ACCESS+	KAISER	WAIVED	DELINQ	TOTAL
CHILD/MINOR DEPENDENTS OF ACTIVE Members	209	0	10,712	0	15,268	0	0	26,189
NO MEDICARE	209		10,711		15,268			26,188
MEDICARE A								
MEDICARE B								
MEDICARE AB								
NON-COMPLIANT			1					1
CHILD/MINOR DEPENDENTS OF RETIRED Members	54	11	139	594	616	0	0	1,414
NO MEDICARE	49	10	134	590	603			1,386
MEDICARE A								
MEDICARE B								
MEDICARE AB	5	1	5	4	13			28
NON-COMPLIANT								
CHILD/MINOR DEPENDENTS OF SURVIVING SPOUSE	8	0	2	32	57	0	0	99
NO MEDICARE	7		2	31	55			95
MEDICARE A								
MEDICARE B								
MEDICARE AB	1			1	2			4
NON-COMPLIANT								
CHILD/MINOR DEPENDENTS OF COMMISSIONERS	4	0	8	0	7	0	0	19
NO MEDICARE	4		8		7			19
MEDICARE A								
MEDICARE B								
MEDICARE AB								
TOTAL DEPENDENTS	**1,799**	**340**	**18,449**	**1,905**	**27,837**	**0**	**0**	**50,330**
MEDICAL PLAN TOTALS	**8,305**	**1,364**	**38,515**	**5,626**	**63,106**	**5,842**	**175**	**122,933**

DENTAL PLAN ENROLLMENT

MEMBERSHIP STATUS	DLTDEN	DLCDEN	PUDDEN	WAIVED	DELINQ	TOT
ACTIVE Members	29,927	799	323	1,868	152	33,(
TIRED Members	16,518	1,051	592	8,313	33	26,(
SURVIVING SPOUSE	1,592	178	64	1,389	28	3,2
COMMISSIONERS	61	8	1	158	2	2
TOTAL MEMBERS	**48,098**	**2,036**	**980**	**11,728**	**215**	**63,(**
SPOUSE/DOM PRT DEPENDENTS OF ACTIVE Members	14,340	263	117			14,7
SPOUSE/DOM PRT DEPENDENTS OF RETIRED Members	6,488	391	184			7,(
SPOUSE/DOM PRT DEPENDENTS OF SURVIVING SPOUSE						
SPOUSE/DOM PRT DEPENDENTS OF COMMISSIONERS	20	1				
CHILD/MINOR DEPENDENTS OF ACTIVE Members	25,106	508	201			25,8
CHILD/MINOR DEPENDENTS OF RETIRED Members	1,451	73	43			1,5
ILD/MINOR DEPENDENTS OF SURVIVING SPOUSE	113	4	2			1
CHILD/MINOR DEPENDENTS OF COMMISSIONERS	22					
TOTAL DEPENDENTS	**47,540**	**1,240**	**547**	**0**	**0**	**49,3**
DENTAL PLAN TOTALS	**95,638**	**3,276**	**1,527**	**11,728**	**215**	**112,3**

LTD, LIFE AND FSA PLAN ENROLLMENT

MEMBERSHIP STATUS	LTD	LIFE	DEPFSA	HTHFSA
ACTIVE Members	24,512	19,004	1,104	3,794

HEALTH SERVICE SYSTEM
CITY & COUNTY OF SAN FRANCISCO

MEMORANDUM

DATE: June 27, 2016

TO: Supervisor Mark Farrell

Board of Supervisors

FROM: Catherine J. Dodd, PhD, RN
Director, Health Service System

RE: Ordinance Approving Health Service System Plans and Contribution Rates for Calendar Year 2017

Attached are the following documents relating to the above matter:

1. Legislative Digest for ordinance approving Health Service System plans and contribution rates for calendar year 2017;
2. Proposed ordinance (approved as to form by the City Attorney's Office) approving Health Service System plans and contribution rates for calendar year 2017;
3. 2016 Ten-County Survey, pursuant to Charter Section A8.423, approved by the Health Service Board on March 10, 2016;
4. Actuarial Report dated June 27, 2016 from Aon Hewitt, as required under Section A8.422 of Appendix A to the San Francisco Charter, including summaries of the rates and benefits adopted by the Health Service Board on May 12, June 9 and June 21, 2016;
5. Membership Enrollment Statistics Report dated June 1, 2016 reflecting total enrollment distribution across the three medical plans, the dental plans and life and long-term disability; and
6. Form SFEC-126 (Notification of Contract Approval) for the following vendors: Kaiser Foundation Health Plan (Northern and Southern California Regions), Blue Shield of California, United HeathCare Services, Inc. (City Plan), Delta Dental of California, Pacific Union Dental (a subsidiary of United HealthGroup), Vision Service Plan, Aetna Life Insurance Company and Best Doctors.

Please let me know if you need additional information.

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

1145 Market Street, 3rd Floor San Francisco, CA 94103
Phone: (415) 554-1750 or 1-800-541-2266 Fax: (415) 554-1721
myhss.org

Print Form

Introduction Form

By a Member of the Board of Supervisors or the Mayor

Time stamp
or meeting date

I hereby submit the following item for introduction (select only one):

☒ 1. For reference to Committee. (An Ordinance, Resolution, Motion, or Charter Amendment)

☐ 2. Request for next printed agenda Without Reference to Committee.

☐ 3. Request for hearing on a subject matter at Committee.

☐ 4. Request for letter beginning "Supervisor _____ inquires"

☐ 5. City Attorney request.

☐ 6. Call File No. _____ from Committee.

☐ 7. Budget Analyst request (attach written motion).

☐ 8. Substitute Legislation File No. _____

☐ 9. Reactivate File No. _____

☐ 10. Question(s) submitted for Mayoral Appearance before the BOS on _____

Please check the appropriate boxes. The proposed legislation should be forwarded to the following:

☐ Small Business Commission ☐ Youth Commission ☐ Ethics Commission

☐ Planning Commission ☐ Building Inspection Commission

Note: For the Imperative Agenda (a resolution not on the printed agenda), use a Imperative Form.

Sponsor(s):

Supervisor Mark Farrell

Subject:

Administrative Code - Health Service System Plans and Contribution Rates for Calendar Year 2017

The text is listed below or attached:

Ordinance approving Health Service System plans and contribution rates for calendar year 2017.

Signature of Sponsoring Supervisor: _____

For Clerk's Use Only:

BOS-11, COB, Leg Dep. B+F, Dep. City Atty Mayors Office

President, District 5
BOARD of SUPERVISORS

City Hall
1 Dr. Carlton B. Goodlett Place, Room 244
San Francisco 94102-4689
Tel. No. 554-7630
Fax No. 554-7634
TDD/TTY No. 544-5227

London Breed

PRESIDENTIAL ACTION

Date: July 11, 2016

To: Angela Calvillo, Clerk of the Board of Supervisors

Madam Clerk,
Pursuant to Board Rules, I am hereby:

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

File No. 160747 Farrell
(Primary Sponsor)

Title. Administrative Code - Health Service System Plans and Contribution Rates for Calendar Year 2017

☐ Transferring (Board Rule No 3.3)

File No. _____ _____
(Primary Sponsor)

Title. _____

From: _____ Committee

To: _____ Committee

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

Supervisor _____

Replacing Supervisor _____

For: _____ _____ Meeting
(Date) (Committee)

RECEIVED
BOARD OF SUPERVISORS
SAN FRANCISCO
2016 JUL 11 AM 11:27
BY

London Breed

London Breed, President
Board of Supervisors

FORM SFEC-126:
NOTIFICATION OF CONTRACT APPROVAL
(S.F. Campaign and Governmental Conduct Code § 1.126)

City Elective Officer Information *(Please print clearly.)*	
Name of City elective officer(s):	City elective office(s) held:

Contractor Information *(Please print clearly.)*

Name of contractor:

Kaiser Foundation Health Plan, Inc., Northern California

Kaiser Foundation Health Plan, Inc., Southern California

Please list the names of (1) members of the contractor's board of directors; (2) the contractor's chief executive officer, chief financial officer and chief operating officer; (3) any person who has an ownership of 20 percent or more in the contractor; (4) any subcontractor listed in the bid or contract; and (5) any political committee sponsored or controlled by the contractor. Use additional pages as necessary.

1. Please see attachment.
2. Please see attachment.
3. Kaiser Permanente is one of the nation's largest not-for-profit prepaid group practice plans, which represents a partnership between Kaiser Foundation Health Plan, Inc. and Kaiser Foundation Hospitals and the Permanente Medical Groups. As such, there is no owner, shareholders or sponsor.

   Health Plans and Hospitals are nonprofit corporations whose capital is available for charitable, educational, research and related purposes and are generally exempt from federal and state income taxes. No individual or entity has any ownership interest in Health Plans or Hospitals.
4. Not applicable
5. Not applicable

Contractor address:

Northern California:
Kaiser Foundation Health Plan, Inc.
1950 Franklin Street
Oakland, CA 94612

Southern California:
Kaiser Foundation Health Plan, Inc.
393 East Walnut Street
Pasadena, CA 91188

Date that contract was approved:	Amount of contract: (Estimated for CY 2017)
June 21, 2016	**$ 373,909,247**

Describe the nature of the contract that was approved:
Medical Health Insurance: Kaiser Permanente Traditional Plan, HMO and Senior Advantage with Part D.

Comments: *The amount of this contract is based on the most recent actuarial information and will change due to employee resignations, new hires, terminations and other attrition factors, as well as member selections at the time of qualifying events.

This contract was approved by (check applicable):

☐ the City elective officer(s) identified on this form

☐ a board on which the City elective officer(s) serves _____
Print Name of Board

☐ the board of a state agency (Health Authority, Housing Authority Commission, Industrial Development Authority Board, Parking Authority, Redevelopment Agency Commission, Relocation Appeals Board, Treasure Island Development Authority) on which an appointee of the City elective officer(s) identified on this form sits

_____
Print Name of Board

Filer Information (*Please print clearly.*)	
Name of filer:	Contact telephone number:
Address:	E-mail:

_____ _____
Signature of City Elective Officer (if submitted by City elective officer) Date Signed

_____ _____
Signature of Board Secretary or Clerk (if submitted by Board Secretary or Clerk) Date Signed

Health Service System – City and County of San Francisco
Attachment to Form SFEC-126:
Notification of Contract Approval
May 2016

- **Please list the names of (1) members of the contractor's board of directors.**

Here are the members of the Kaiser Foundation Hospitals and Health Plan Boards of Directors:

Bernard J. Tyson
Chairman and CEO of Kaiser Permanente

Ramon Baez
Kaiser Foundation Hospitals and Health Plan Boards of Directors

Regina Benjamin, MD, MBA
Kaiser Foundation Hospitals and Health Plan Boards of Directors

Jeff Epstein
Kaiser Foundation Hospitals and Health Plan Boards of Directors

Leslie Stone Heisz
Kaiser Foundation Hospitals and Health Plan Boards of Directors

David F. Hoffmeister
Kaiser Foundation Hospitals and Health Plan Boards of Directors

Judith A. Johansen, JD
Kaiser Foundation Hospitals and Health Plan Boards of Directors

Kim J. Kaiser
Kaiser Foundation Hospitals and Health Plan Boards of Directors

Philip A. Marineau
Kaiser Foundation Hospitals and Health Plan Boards of Directors

Edward Pei
Kaiser Foundation Hospitals and Health Plan Boards of Directors

Meg Porfido, JD
Kaiser Foundation Hospitals and Health Plan Boards of Directors

Richard P. Shannon, MD
Kaiser Foundation Hospitals and Health Plan Boards of Directors

Cynthia A. Telles, PhD
Kaiser Foundation Hospitals and Health Plan Boards of Directors

A. Eugene Washington, MD, MPH
Kaiser Foundation Hospitals and Health Plan Boards of Directors

For more information on the members of our Boards of Directors, please go to http://share.kaiserpermanente.org/bio/.

- **Please list the names of (2) the contractor's chief executive officer, chief financial officer, and chief operating officer.**

Bernard J. Tyson
Chairman and CEO of Kaiser Permanente

Kathy Lancaster
Executive Vice President and Chief Financial Officer, Kaiser Foundation Hospitals and Health Plan

We do not have a "Chief Operating Officer" for Hospitals and Health Plan — following are the other members of our National Leadership Team:

Gregory A. Adams
Executive Vice President, Kaiser Foundation Hospitals and Health Plan, Inc.; Group President

Anthony A. Barrueta
Senior Vice President, Government Relations

Raymond J. Baxter, PhD
Senior Vice President, Community Benefit, Research and Health Policy

Vanessa M. Benavides
Senior Vice President and Chief Compliance and Privacy Officer, Kaiser Foundation Hospitals and Health Plan, Inc.

Benjamin K. Chu, MD, MPH, MACP
President, Kaiser Permanente Southern California Region; Group President, Kaiser Permanente Southern California and Georgia Regions; Executive Vice President, Kaiser Foundation Hospitals and Kaiser Foundation Health Plan, Inc.

Chuck Columbus
Senior Vice President and Chief Human Resources Officer, Kaiser Foundation Hospitals and Health Plan, Inc.

Patrick T. Courneya, MD
Executive Vice President, Hospitals, Quality and Care Delivery Excellence; Chief Medical Officer, Medicare Advantage, Cost and Prescription Drug Plans

Richard D. Daniels
Executive Vice President and Chief Information Officer, Kaiser Foundation Hospitals and Health Plan, Inc.

Donna Lynne, DrPH
Executive Vice President, Kaiser Foundation Hospitals and Health Plan, Inc.; Group President, Kaiser Permanente Colorado, Hawaii, Oregon and Washington

Arthur M. Southam, MD, MBA, MPH
Executive Vice President, Health Plan Operations

Mark S. Zemelman
Senior Vice President and General Counsel

Edward M. Ellison, MD
Executive Medical Director/Chairman of the Board, Southern California Permanente Medical Group; Chairman of the Board and CEO, The Southeast Permanente Medical Group; co-CEO, National Permanente Executive Committee, The Permanente Federation, LLC

Robert M. Pearl, MD
Executive Director and CEO, The Permanente Medical Group; President and CEO, Mid-Atlantic Permanente Medical Group; co-CEO, National Permanente Executive Committee, The Permanente Federation, LLC

Geoffrey S. Sewell, MD, FACP
President and Executive Medical Director, Hawaii Permanente Medical Group, Inc.; Chairman, National Permanente Executive Committee, The Permanente Federation, LLC

Chris Grant
Executive Vice President, Chief Operating Officer, Kaiser Permanente, The Permanente Federation

David Bell, MD
Executive Vice President of Leadership and People Strategy, The Permanente Federation; Corporate Vice President and Associate Medical Director for Professional Development and Service, Hawaii Permanente Medical Group

Pat Conolly, MD
Executive Vice President of Information Technology and Chief Information Officer, The Permanente Federation; Associate Executive Director, The Permanente Medical Group

Pauline Fox
Executive Vice President and Chief Legal Officer, The Permanente Federation, LLC; Interim General Counsel, Colorado Permanente Medical Group

Michael Kanter, MD
Executive Vice President of Quality and Chief Medical Officer, The Permanente Federation; Medical Director, Quality and Clinical Analysis, Southern California Permanente Medical Group

Daryl Kurozawa, MD, FACS
Executive Vice President of Products/Sales & Marketing, The Permanente Federation; Associate Medical Director, Sales & Marketing, Service Delivery Planning and Community Benefit, Hawaii Permanente Medical Group

Sharon Levine, MD
Executive Vice President, External Affairs, Communications and Brand Strategy, The Permanente Federation; Director and Senior Advisor of Public Policy, Pharmacy, and Professional Development, The Permanente Medical Group

Paul Minardi, MD
Executive Vice President, Finance and Strategy, The Permanente Federation; Medical Director, Business Management, Southern California Permanente Medical Group

Rochele Thornburg
Executive Vice President, Leadership and People Strategy, The Permanente Federation; Vice President, Strategy, Leadership, and Communications, Hawaii Permanente Medical Group

FORM SFEC-126:
NOTIFICATION OF CONTRACT APPROVAL
(S.F. Campaign and Governmental Conduct Code § 1.126)

City Elective Officer Information *(Please print clearly.)*	
Name of City elective officer(s):	City elective office(s) held:

Contractor Information *(Please print clearly.)*

Name of contractor:
Blue Shield of California

Please list the names of (1) members of the contractor's board of directors; (2) the contractor's chief executive officer, chief financial officer and chief operating officer; (3) any person who has an ownership of 20 percent or more in the contractor; (4) any subcontractor listed in the bid or contract; and (5) any political committee sponsored or controlled by the contractor. Use additional pages as necessary.

(1) members of the contractor's board of directors:

- Paul Markovich
- Robert Lee, Chairman
- Doug Busch
- Gary Cohen
- Evelyn Dilsaver
- Helen DuPlessis, M.D., M.P.H.
- Hector Flores, M.D.
- Alan Fohrer
- Kristina M. Leslie
- Leon E. Panetta
- Mohammad H. Qayoumi, Ph.D.

(2) the contractor's chief executive officer, chief financial officer and chief operating officer;

Paul Markovick, President & CEO

Michael Murray, Senior Vice President and Chief Financial Officer

(3) any person who has an ownership of 20 percent or more in the contractor;

Blue Shield is a Not-for-Profit Mutual Benefit Corporation.

(4) any subcontractor listed in the bid or contract; and

Blue Shield currently contracts with the following vendors to provide cost-effective, quality healthcare services:

- **Accent Company, Omaha, NE (2003)** – Accent provides investigation and recovery functions related to workers' compensation and third-party liability.
- **Xerox, Sandy, UT (2011)** – Xerox provides member enrollment data entry services.
- **TPUSA, Los Angeles, CA (2007)** – TPUSA assists with handling calls from Individual and Family Plan (IFP) members as well as eligibility and billing questions for members with portfolio plans.
- **Optum, Waltham, MA (2003)** – Optum currently administers Blue Shield's Predictive Triage Engine, disease management programs; a suite high-risk case management programs; chronic complex, prenatal, and musculoskeletal case management programs CareTips clinical care gap messaging for members and providers; and our NurseHelp 24/7 program.
- **American Specialty Health Plans, San Diego, CA (1994)** – American Specialty Health Plans provides access to their chiropractic, acupuncture, and podiatry networks.
- **Argus Health Systems, Kansas City, MO (1999)** – Argus Health Systems provides claims processing for pharmacy benefits. Blue Shield provides pharmacy benefit management, pharmacy network, formulary, prior authorization, and member services internally.
- **Healthways, Franklin, TN (2013)** - Healthways provides the online wellness platform and content for Wellvolution including the Wellbeing Tracker and Daily Challenge.
- **VAL Health, Paoli, PA (2014)** – VAL Health manages a financial incentive program designed using behavioral economics theory integrated with wellness programs
- **CVS Specialty Redlands, CA (2005) and Walgreens Specialty, Beaverton, OR (2013)** – CVS Specialty and Walgreens Specialty provides specialty pharmacy services.
- **Dental Benefit Providers, Columbia, MD (1988)** – Dental Benefit Providers serves as Blue Shield's dental plan administrator.
- **DST Output, El Dorado Hills, CA (2002)** – DST Output provides production services for explanation of benefits documents.
- **Arvato, Valencia, CA (2015)** – Arvato provides production services for ID cards.
- **Hewlett Packard, Plano, TX (2001)** – Hewitt Packard provides information systems and reporting services.
- **Trizetto Cognizant, Englewood, CO (2015)** - Trizetto Cognizant provides information systems and reporting services.
- **HealthEquity, Draper, UT (2012)** – HealthEquity provides integrated HSA/HRA/FSA consumer directed healthcare services for our high deductible health plans (HDHP).
- **Healthwise, Boise, ID (2005)** – Healthwise, a nonprofit consumer health content provider, supplies a robust health and wellness knowledgebase product for use on our website, www.blueshieldca.com.
- **Hinduja Global Solutions Inc., Warrenville, IL. (2011)** – Hinduja provides claims edit resolution services.

- **LabCorp, Burlington, NC (1997)** – LabCorp provides access to a national network of clinical laboratories.
- **Language Line, Monterey, CA (2002)** – Language Line provides language services to assist non-English speaking members.
- **Magellan Health Services, Avon, CT (2012)** – Magellan Health Services serves as Blue Shield's Mental Health Service Administrator (MHSA), providing mental health/substance abuse network administration, claims, customer service, care management, and medical management. Additionally, they administer our LifeReferrals 24/7 program and a Behavioral Health Depression Management Program that integrates with our disease management program.
- **MES Vision, Santa Ana, CA (1984)** – Medical Eye Services serves as Blue Shield's vision plan administrator.
- **National Imaging Associates, Columbia, MD (1999)** – National Imaging Associates provides prior authorization and medical management for outpatient radiology services, including CAT scans, MRIs/MRAs, nuclear cardiology, bone densitometry, and PET scanning.
- **PrimeMail, Eagan, MN (2008)** – PrimeMail provides mail service for pharmacy benefits. Blue Shield provides pharmacy benefit management, pharmacy network, formulary, prior authorization, and member services internally.
- **Quest Diagnostics, Madison, NJ (2008)** – Quest Diagnostics provides onsite and remote biometric screening services and immunization services.
- **SourceHOV, LLC, Dallas, TX. (2007)** – SourceHOV provides paper claims and correspondence mailroom, imaging and data entry services, including image viewing capabilities, claims edit resolution, correspondence activation, small group enrollment, claim credit backs, and pre-denial audits.
- **TeleTech Financial Services Management, LLC, Englewood, CO (2001)** – TeleTech assists with handling phone calls for IFP members, eligibility and billing questions for members with portfolio plans, and providers.
- **eviCore, Inc., Plainville CT (2011) –** eviCore provides prior authorization for spine surgery and interventional pain procedures.
- **Partners in Care Foundation, San Fernando, CA (2015) –** Partners in Care Foundation currently administers a home visit component of Shield Support care management, as well as a pilot of Evidence-Based Self- Management Programs for members with chronic conditions (provided as an additional option for members enrolled in BSC disease management program).
- **The Health Trust, San Jose, CA (2015) –** The Health Trust currently administers a pilot of Evidence-Based Self-Management Program for members with chronic conditions (provided as an additional option for members enrolled in BSC disease management program).

Please note that Blue Shield providers are neither agents nor employees of the plan but are independent contractors. Blue Shield cannot be held liable for the negligence, wrongful acts or omissions of any person receiving or providing services, including any physician, hospital or other provider.

(5) any political committee sponsored or controlled by the contractor. EmPAC
Contractor address: 50 Beale Street, San Francisco CA 94105

Date that contract was approved: **June 21, 2016**	Amount of contract: (Estimated for CY 2017) **$ 314,669,244**

Describe the nature of the contract that was approved: Medical Coverage: Blue Shield Flex Funded HMO for Actives and Early Retirees, and MAPD/COB for Retirees.
Comments: *The amount of this contract is based on the most recent actuarial information and will change due to employee resignations, new hires, terminations and other attrition factors, as well as member selections at the time of qualifying events.

This contract was approved by (check applicable):

☐ the City elective officer(s) identified on this form _____

☐ a board on which the City elective officer(s) serves _____
Print Name of Board

☐ the board of a state agency (Health Authority, Housing Authority Commission, Industrial Development Authority Board, Parking Authority, Redevelopment Agency Commission, Relocation Appeals Board, Treasure Island Development Authority) on which an appointee of the City elective officer(s) identified on this form sits

_____

—

Print Name of Board

Filer Information *(Please print clearly.)*	
Name of filer:	Contact telephone number:
Address:	E-mail:

_____

Signature of City Elective Officer (if submitted by City elective officer) Date Signed

_____

Signature of Board Secretary or Clerk (if submitted by Board Secretary or Clerk) Date Signed

FORM SFEC-126:
NOTIFICATION OF CONTRACT APPROVAL
(S.F. Campaign and Governmental Conduct Code § 1.126)

City Elective Officer Information *(Please print clearly.)*	
Name of City elective officer(s):	City elective office(s) held:

Contractor Information *(Please print clearly.)*

Name of contractor: United HealthCare Services, Inc. (for City Plan)

Please list the names of (1) members of the contractor's board of directors; (2) the contractor's chief executive officer, chief financial officer and chief operating officer; (3) any person who has an ownership of 20 percent or more in the contractor; (4) any subcontractor listed in the bid or contract; and (5) any political committee sponsored or controlled by the contractor. Use additional pages as necessary.

1. The United HealthCare Services, Inc. Directors are :

   - William C. Ballard, Jr.
   - Edson Bueno, M.D.
   - Richard T. Burke
   - Robert J. Darretta
   - Stephen J. Hemsley
   - Michele J. Hooper
   - Rodger A. Lawson
   - Douglas W. Leatherdale
   - Glenn M. Renwick
   - Kenneth I. Shine, M.D.
   - Gail R. Wilensky, Ph.D.

2. The United HealthCare Services, Inc. Officers include:
   CEO and President: Stephen J. Hemsley
   CFO: David S. Wichmann
   COO: Dirk McMahon

3. No person owns 20 percent or more in the contractor.

4. We provide most of our core services directly through the UnitedHealth Group family of companies. This enables us to offer affordable solutions through integrated data elements and systems, streamlined implementations and unified account management support.

   We do work with a variety of external vendors and subcontractors and have listed some of these third parties and the different capacities in which we interact with them. Due to the broad spectrum of UnitedHealth Group businesses and variations in the contractual relationships we have with each vendor or subcontractor, this list is subject to change and should not be considered exhaustive.

   VENDORS AND SUBCONTRACTORS

   ID CARDS

   Our member medical ID cards are produced by Fiserv Output Solutions, a business unit of Fiserv, Inc. Fiserv, headquartered in Stafford, Texas, is a provider of business-critical communications to the financial services, health care, telecommunications, investment services and retail markets.

HEALTH INFORMATION

Various internal and external sources provide health content to our member website, **myuhc.com**. Each resource maintains relationships with various health professionals who write, edit and review the content created for the site. We screen each vendor for accuracy and independence of content.

OVERPAYMENT IDENTIFICATION VENDORS

We contract with a number of vendors to identify overpayments. These vendors perform a variety of audits, including, but not limited to, credit balance, data mining, COB, contract audits, DRG audits, workers' compensation and subrogation. Generally, these vendors do not perform collections on the overpayments they identify in an effort to reduce the number of vendors approaching physicians. A collection vendor is assigned to collect these overpayments.

OVERPAYMENT COLLECTION VENDORS

We contract with a number of vendors to collect overpayments that are identified internally or from an overpayment identification vendor. Overpayment collection vendors are responsible for sending the initial overpayment notification letter and will follow up with the physician on outstanding balances through phone calls or subsequent recovery letters. These vendors help resolve physician disputes/appeals.

SURVEYS

We conduct an annual member satisfaction survey based upon the HEDIS 3.0 standards.

Administration of the CAHPS survey is a joint effort between the Survey Research Studies division of OptumInsight (a UnitedHealth Group company) and the Center for the Study of Services (CSS). CSS is certified by NCQA as a CAHPS survey vendor.

NETWORK LEASING

We own the majority of networks we use for providing health care coverage. However, we use leased or vendor networks where it is not feasible to develop our own network. Vendor networks must comply with the same quality standards we use for our own networks. Vendor network compensation varies based on market demands and the customary practices of the local marketplace. We retain responsibility for claim processing. In addition, we oversee all quality issues, including quality control of the physicians and other health care professionals in the network.

SHARED SAVINGS PROGRAM

We use Viant, Three Rivers Physician's Network, First Health Networks and MultiPlan's national network of hospitals, physicians and other health care professionals to provide discounts to our customers for non-network claims through our Shared Savings Program (SSP).

SOCIAL SECURITY ADVOCACY ASSISTANCE

Social Security advocacy assistance is provided through another vendor. Claim specialists are trained to educate, guide and monitor the application process for Social Security disability benefits. We then consider offering assistance through Social Security Advocacy for the Disabled.

LEGAL

We hold our vendors to the same standards and requirements to which we agree. We accept responsibility to the extent that our subcontracted vendor fails to meet any contractual obligation we assume.

5. In California, corporate contributions are legal, and all of our political giving is reported by United HealthCare Services, Inc., a corporate entity that registers as a major donor committee with the state. We are happy to provide additional information at the parent company level (UnitedHealth Group, Inc.) for states other than California, upon request.

Contractor address: UnitedHealth Group Center 9900 Bren Road East Minnetonka, Minnesota 55343	
Date that contract was approved: **June 21, 2016**	Amount of contract: (Estimated for CY 2017) **$79,493,483**
Describe the nature of the contract that was approved: Self-Insured Medical Plan and Prescription Drug sponsored by CCSF and whose claims administration is outsourced to UnitedHealth Services, Inc., as well as a fully insured Plan for Medicare A and B retirees	
Comments:* The amount of this contract is based on the most recent actuarial information and will change due to actual claims, employee resignations, new hires, terminations and other attrition factors, as well as member selections at the time of qualifying events.	

This contract was approved by (check applicable):

☐ the City elective officer(s) identified on this form

☐a board on which the City elective officer(s) serves _____
Print Name of Board

☐ the board of a state agency (Health Authority, Housing Authority Commission, Industrial Development Authority Board, Parking Authority, Redevelopment Agency Commission, Relocation Appeals Board, Treasure Island Development Authority) on which an appointee of the City elective officer(s) identified on this form sits

_____
Print Name of Board

Filer Information *(Please print clearly.)*	
Name of filer:	Contact telephone number:
Address:	E-mail:

_____
Signature of City Elective Officer (if submitted by City elective officer) Date Signed

_____
Signature of Board Secretary or Clerk (if submitted by Board Secretary or Clerk) Date Signed

ORM SFEC-126:
NOTIFICATION OF CONTRACT APPROVAL
(S.F. Campaign and Governmental Conduct Code § 1.126)

City Elective Officer Information *(Please print clearly.)*	
Name of City elective officer(s):	City elective office(s) held:

Contractor Information *(Please print clearly.)*

Name of contractor:
Delta Dental of California (Delta Dental PPO Active Self Insured and Retiree PPO fully insured, and DeltaCare DHMO)

Please list the names of (1) members of the contractor's board of directors; (2) the contractor's chief executive officer, chief financial officer and chief operating officer; (3) any person who has an ownership of 20 percent or more in the contractor; (4) any subcontractor listed in the bid or contract; and (5) any political committee sponsored or controlled by the contractor. Use additional pages as necessary.

(1)DIRECTORS AND OFFICERS

Glen F. Bergert
100 First Street
San Francisco, CA 94105

Barbara J. Burgel
100 First Street
San Francisco, CA 94105

D. Douglas Cassat, DDS
100 First Street
San Francisco, CA 94105

Aidan M. Collins
100 First Street
San Francisco, CA 94105

R. Kent Farnsworth, DDS
100 First Street
San Francisco, CA 94105

Lynn L. Franzoi, **1st Vice Chair**
100 First Street
San Francisco, CA 94105

Devang M. Gandhi, DDS
100 First Street
San Francisco, CA 94105

Roy A. Gonella, **Secretary**
100 First Street
San Francisco, CA 94105

Gregory D. Kaplan, DDS
100 First Street

San Francisco, CA 94105

Beverly A. Kodama, DDS
100 First Street
San Francisco, CA 94105

Terry A. O'Toole, **Treasurer**
100 First Street
San Francisco, CA 94105

Stephen R. Pickering, DDS, **2nd Vice Chair**
100 First Street
San Francisco, CA 94105

Jo Bonita Rains
100 First Street
San Francisco, CA 94105

Andrew J. Reid, **Chair**
100 First Street
San Francisco, CA 94105

Thomas A. Zimmerman
100 First Street
San Francisco, CA 94105

Anthony S. Barth (Ex Officio)
100 First Street
San Francisco, CA 94105

(2)
President/Chief Executive Officer – Anthony S. Barth
Chief Financial Officer – Michael J. Castro
Chief Operations Officer -- Nilesh C. Patel

(3)
None

(4)
None

(5)
None

Contractor address:
100 First Street, San Francisco, California 94105

Date that contract was approved: **June 21, 2016**	Amount of contract: (estimated for CY 2017) Delta Dental PPO - Policy Number 01673 – Retirees (fully-insured premium) • **$13,100,000** Delta Dental PPO - Policy Number 09502 – Actives (self-funded claims + admin.) • **$44,400,000** (includes $1.57M in Admin.) DeltaCare USA – DHMO Policy Number 71797 – DeltaCare (fully-insured premium) • **$1,000,000**
Describe the nature of the contract that was approved: Dental Benefits	
Comments: The amount of this contract is based on the most recent information and will change due to employee resignations, new hires, terminations and other attrition factors, as well as member selections at the time of qualifying events. The Delta Dental PPO Active Self-Insured Plan is based on actual claims and administration.	

This contract was approved by (check applicable):

☐ the City elective officer(s) identified on this form

☐ a board on which the City elective officer(s) serves _____
Print Name of Board

☐ the board of a state agency (Health Authority, Housing Authority Commission, Industrial Development Authority Board, Parking Authority, Redevelopment Agency Commission, Relocation Appeals Board, Treasure Island Development Authority) on which an appointee of the City elective officer(s) identified on this form sits

_____

—
Print Name of Board

Filer Information *(Please print clearly.)*	
Name of filer:	Contact telephone number:
Address:	E-mail:

_____

Signature of City Elective Officer (if submitted by City elective officer) Date Signed

_____

Signature of Board Secretary or Clerk (if submitted by Board Secretary or Clerk) Date Signe

FORM SFEC-126:
NOTIFICATION OF CONTRACT APPROVAL
(S.F. Campaign and Governmental Conduct Code § 1.126)

City Elective Officer Information *(Please print clearly.)*	
Name of City elective officer(s):	City elective office(s) held:

Contractor Information *(Please print clearly.)*

Name of contractor:
DENTAL BENEFIT PROVIDERS OF CALIFORNIA, INC., an indirect subsidiary of UnitedHealth Group [Pacific Union]

Please list the names of (1) members of the contractor's board of directors; (2) the contractor's chief executive officer, chief financial officer and chief operating officer; (3) any person who has an ownership of 20 percent or more in the contractor; (4) any subcontractor listed in the bid or contract; and (5) any political committee sponsored or controlled by the contractor. Use additional pages as necessary.

1. The Dental Benefit Providers of California, Inc. Directors are:
   - Kirk Eugene Andrews
   - Brandon Eric Cuevas
   - Andrew Joseph Fabula
   - Kenneth Mark Sheldon
   - Paul Ryan Toler.

2. The Dental Benefit Providers of California, Inc. officers include:
   - **President:** Kirk Eugene Andrews
   - **CFO:** William David Aliski (Note: the Board is in the process of appointing Paul Ryan Toler as CFO)

3. Dental Benefit Providers, Inc. is 100% shareholder of Dental Benefit Providers of California, Inc.

4. We provide most of our core services directly through the UnitedHealth Group family of companies. This allows us to offer affordable solutions through integrated data elements and systems, streamlined implementations and unified account management support.

   We do work with a variety of external vendors and subcontractors and have listed some of these third parties and the different capacities in which we interact with them. Due to the broad spectrum of UnitedHealth Group businesses and variations in the contractual relationships we have with each vendor or subcontractor, this list is subject to change and should not be considered exhaustive. We will be responsible for holding our vendors to the same standards and requirements to which we agree. We will accept responsibility to the extent that our subcontracted vendor fails to meet any contractual obligation assumed by us.

Following are examples of non-affiliated organizations with which we subcontract for dental services:

- **Careington** augments our national dental network. We have been working with Careington since 2010.
- **Datamatics Global Services** (formerly Tricom) performs data entry of some of our claims in India. We have been working with this company since 2005.
- **Diversified Dental Service** augments our dental networks in Mississippi and Nevada. We have been working with Diversified Dental since 2005.
- **Emdeon** assists with HIPAA transactions and code sets. We have been working with Emdeon since 1997.
- **GfK Custom Research** conducts our member surveys. We have been working with GfK since 2010.
- **P & R Dental Strategies, Inc.** performs utilization review for our commercial dental business. We have been working with P&R since 2005.
- **PPOUSA** adds additional dental providers nationally. We have been working with PPOUSA since 2008.
- **The Premier Dental Group, Inc.** augments our dental network in Minnesota. We have been working with Premier Dental Group since 2007.
- **Scion Dental, Inc.** handles utilization review, and network recruitment. We have been working with Scion since 2009.
- **SourceHOV** (formerly HOV Services) receives and images paper claims. UnitedHealth Group has used this subcontractor since 1998 and we began using them for dental claims in 2005.
- **Southland Benefit Solutions, LLC**, provides our network lease in Alabama.
- **TeleTech** receives all incoming provider phone calls in Lipa City, Philippines. UnitedHealth Group has used this subcontractor since 1996 and we began using TeleTech for dental provider calls in 2006.
- **The TriZetto Group, Inc.** supports and maintains our claims system. We have been working with TriZetto since 2002.
- **Verisk Health** performs special investigating unit (SIU) services in support of the fraud, waste and abuse program. We have been working with this company since 2012.

In addition, due to the nature of UnitedHealth Group's corporate structure, some functions are handled by affiliates.

5. In California, corporate contributions are legal, and all of our political giving is through the United HealthCare Services, Inc. corporate entity, which registers as a major donor committee with the state. We are happy to provide additional information at the parent company level (UnitedHealth Group) for states other than California, upon request.

Contractor address: Dental Benefit Providers of California, Inc. 3110 Lake Center Drive Santa Ana, CA 92704	
Date that contract was approved: **June 21, 2016**	Amount of contract:(estimated for CY 2017) **$ 344,095**
Describe the nature of the contract that was approved: DMO Dental Coverage for both active and retirees	
Comments: *The amount of this contract is based on the most recent information and will change due to employee resignations, new hires, terminations and other attrition factors, as well as member selections at the time of qualifying events.	

This contract was approved by (check applicable):

☐ the City elective officer(s) identified on this form

☐a board on which the City elective officer(s) serves _____
Print Name of Board

☐ the board of a state agency (Health Authority, Housing Authority Commission, Industrial Development Authority Board, Parking Authority, Redevelopment Agency Commission, Relocation Appeals Board, Treasure Island Development Authority) on which an appointee of the City elective officer(s) identified on this form sits

_____
Print Name of Board

Filer Information *(Please print clearly.)*	
Name of filer:	Contact telephone number:
Address:	E-mail:

_____
Signature of City Elective Officer (if submitted by City elective officer) Date Signed

_____
Signature of Board Secretary or Clerk (if submitted by Board Secretary or Clerk) Date Signed

FORM SFEC-126:
NOTIFICATION OF CONTRACT APPROVAL
(S.F. Campaign and Governmental Conduct Code § 1.126)

City Elective Officer Information *(Please print clearly.)*	
Name of City elective officer(s):	City elective office(s) held:

Contractor Information *(Please print clearly.)*	
Name of contractor: Vision Service Plan (VSP)	
Please list the names of (1) members of the contractor's board of directors; (2) the contractor's chief executive officer, chief financial officer and chief operating officer; (3) any person who has an ownership of 20 percent or more in the contractor; (4) any subcontractor listed in the bid or contract; and (5) any political committee sponsored or controlled by the contractor. Use additional pages as necessary. *1) Matthew Alpert, O.D, Mark Bronstein, M.D., M.M.M., Walter Grubbs., Fred Howard, Gordon W. Jennings, O.D, Randy D. Lee, O.D., Rob Lynch, Dan Mannen, O.D., F.A.A.O., Leslie A. Murphy, CPA, Mary Anne Murphy, O.D., Gary Sheppard, J.D., Stuart J. Thomas, O.D., Ryan Wineinger, O.D.* *2) James Michael McGrann, President/CEO, Kate Renwick-Espinosa, VSP Vision Care President, Don Ball, CFO/Global, Les Passuello, CFO/Vision Care, Chief Operating Officer is not applicable.* *3) not applicable, as VSP is a nonprofit corporation* *4) not applicable* *5) not applicable*	
Contractor address: 3333 Quality Drive, Rancho Cordova, CA 95670	
Date that contract was approved: **June 21, 2016**	Amount of contract:(estimated for CY 2017) **$5,160,000**
Describe the nature of the contract that was approved: **Vision insurance**	
Comments: *The amount of this contract is based on the most recent information and will change due to employee resignations, new hires, terminations and other attrition factors, as well as member selections at the time of qualifying events.	

This contract was approved by (check applicable):

☐ the City elective officer(s) identified on this form

☐a board on which the City elective officer(s) serves _____
Print Name of Board

☐ the board of a state agency (Health Authority, Housing Authority Commission, Industrial Development Authority Board, Parking Authority, Redevelopment Agency Commission, Relocation Appeals Board, Treasure Island Development Authority) on which an appointee of the City elective officer(s) identified on this form sits

_____
Print Name of Board

Filer Information (*Please print clearly.*)	
Name of filer:	Contact telephone number:
Address:	E-mail:

Signature of City Elective Officer (if submitted by City elective officer) Date Signed

Signature of Board Secretary or Clerk (if submitted by Board Secretary or Clerk) Date Signed

FORM SFEC-126:
NOTIFICATION OF CONTRACT APPROVAL
(S.F. Campaign and Governmental Conduct Code § 1.126)

City Elective Officer Information *(Please print clearly.)*	
Name of City elective officer(s):	City elective office(s) held:

Contractor Information *(Please print clearly.)*

Name of contractor:
Aetna Life Insurance Company

Please list the names of (1) members of the contractor's board of directors; (2) the contractor's chief executive officer, chief financial officer and chief operating officer; (3) any person who has an ownership of 20 percent or more in the contractor; (4) any subcontractor listed in the bid or contract; and (5) any political committee sponsored or controlled by the contractor. Use additional pages as necessary.

(1) Contractor (Aetna) Board of Directors

- *Fernando Aguirre, Former Chairman, President and Chief Executive Officer Chiquita Brands International, Inc.*
- *Mark T. Bertolini Chairman, Chief Executive Officer and President Aetna*
- *Frank M. Clark, Former Chairman and Chief Executive Officer Commonwealth Edison Company*
- *Betsy Z. Cohen, Chief Executive Officer The Bancorp, Inc*
- *Molly J. Coye, M.D., Chief Innovation Officer UCLA Health System*
- *Roger N. Farah, President, Chief Operating Officer and Director Ralph Lauren Corporation*
- *Jeffrey E. Garten, Juan Trippe Professor in the Practice of International Trade, Finance and Business, Yale University*
- *Ellen M. Hancock, Former President of Jazz Technologies, Inc., Former Chairman and Chief Executive Officer of Exodus Communications, Inc.*
- *Richard J. Harrington, Chairman The Cue Ball Group, Former President and Chief Executive Officer The Thomson Corporation*
- *Edward J. Ludwig, Former Chairman and Chief Executive Officer Becton, Dickinson and Company*
- *Joseph P. Newhouse, John D. MacArthur Professor of Health Policy and Management Harvard University*
- *Olympia J. Snowe, Chairman and Chief Executive Officer, Olympia Snowe, LLC, Former U. S. Senator*

(2) Contractor (Aetna) Chief Executive Officer/Chief Financial Officer/Chief Operating Officer

- *Mark T. Bertolini Chairman, Chief Executive Officer*
- *Karen S. Lynch, President*
- *Shawn Guertin, Senior Executive Vice President, Chief Financial Officer*
- *Meg McCarthy is Executive Vice President, Operations & Technology.*

(3) Any person who has an ownership of 20% or more

- *Aetna is a publically traded company with no one person or entity having 20% or more ownership*

(4) Any subcontractor listed in the bid.

- *Affiliated Customer Services*
- *Allsup*
- *Computer Sciences Corporation*
- *Coventry Priority Services*
- *IBM Daksh*
- *International Beneficiary Locators, Inc.*
- *Intracorp*
- *Open Solutions and Harland (formerly BISYS)*
- *Perot*
- *The Rawlings Company*

(5) Any Political committee sponsored or controlled by the contractor

- *Aetna Political Action Committee (PAC)*
  - *i. Aetna PAC is a bipartisan political action committee, an organization that enables company employees to have a voice with legislators who make laws and policy that have a direct impact on the way the company does business. Its purpose is to collect voluntary contributions from eligible Aetna employees*

and then use these funds to support candidates for federal and state political office in accordance with applicable election laws.
Contractor address: 151 Farmington Avenue Hartford, CT 06156
Date that contract was approved: **June 21, 2016** Amount of contract: (estimated for CY 2017) • Life (basic): **$940,000** • Life (Supplemental): **$2,500,000** • Long Term Disability(LTD)**: $6,870,000** TOTAL: **$10,310,000**
Describe the nature of the contract that was approved: **1.) Basic Group Life and Supplemental Life, and;** **2.) Long Term Disability Insurance**
Comments: *The amount of this contract is based on the most recent information and will change due to employee resignations, new hires, terminations and other attrition factors, as well as member selections at the time of qualifying events.

This contract was approved by (check applicable):

☐ the City elective officer(s) identified on this form _____

☐ a board on which the City elective officer(s) serves _____
Print Name of Board

☐ the board of a state agency (Health Authority, Housing Authority Commission, Industrial Development Authority Board, Parking Authority, Redevelopment Agency Commission, Relocation Appeals Board, Treasure Island Development Authority) on which an appointee of the City elective officer(s) identified on this form sits

_____
Print Name of Board

Filer Information *(Please print clearly.)*	
Name of filer:	Contact telephone number:
Address:	E-mail:

_____ _____
Signature of City Elective Officer (if submitted by City elective officer) Date Signed

_____ _____
Signature of Board Secretary or Clerk (if submitted by Board Secretary or Clerk) Date Signed

FORM SFEC-126:
NOTIFICATION OF CONTRACT APPROVAL
(S.F. Campaign and Governmental Conduct Code § 1.126)

City Elective Officer Information *(Please print clearly.)*	
Name of City elective officer(s):	City elective office(s) held:

Contractor Information *(Please print clearly.)*

Name of contractor: **Best Doctors, Inc.**

1) *Please list the names of members of the contractor's board of directors:*
   - Douglas Donahue,
   - Bradley Langer,
   - Jeffrey Meskin,
   - Jeff Price,
   - Peter McClennen,
   - Nancy Falchuk,
   - Douglas Maine,
   - Elizabeth Allen,
   - Ignacio Rivera, and
   - Jack Wolf

2) *the contractor's chief executive officer, chief financial officer and chief operating officer:*
   - Peter McClennen, CEO
   - John MacLean, CFO
   - John Vavarias, COO

3) *(3) any person who has an ownership of 20 percent or more in the contractor:*
   - No one person has ownership of 20 percent or more of the company.

4) *any subcontractor listed in the bid or contract:*
   - N/A

5) *any political committee sponsored or controlled by the contractor.*
   - N/A

Contractor address: 60 State Street #600, Boston, MA, 02109

Date that contract was approved:	Amount of contract: (estimated for CY 2017)
June 21, 2016	**$ 1,118,880**

Describe the nature of the contract that was approved:
Best Doctors provides a Second Medical Opinion benefit, beyond what is offered through Health Plans.

Comments:
*The amount of this contract is based on the most recent information and will change due to employee resignations, new hires, terminations and other attrition factors, as well as member selections at the time of qualifying events.

This contract was approved by (check applicable):

☐ the City elective officer(s) identified on this form _____

☐ a board on which the City elective officer(s) serves _____
Print Name of Board

☐ the board of a state agency (Health Authority, Housing Authority Commission, Industrial Development Authority Board, Parking Authority, Redevelopment Agency Commission, Relocation Appeals Board, Treasure Island Development Authority) on which an appointee of the City elective officer(s) identified on this form sits

_____
Print Name of Board

Filer Information *(Please print clearly.)*	
Name of filer:	Contact telephone number:
Address:	E-mail:

Signature of City Elective Officer (if submitted by City elective officer) Date Signed

Signature of Board Secretary or Clerk (if submitted by Board Secretary or Clerk) Date Signed

File #160747
Received in Committee
7/20/16

PROTECT OUR BENEFITS
SAN FRANCISCO

"A Political Action Committee"

www.protectourbenefits.com

July 11 2016

Supervisor Mark Farrell
Chair, Budget and Finance Committee
Board of Supervisors
1 Carlton B. Goodlett Place
San Francisco, CA 94102

RE: Ordinance Approving Health Service System Plans and Contribution Rates for 2017

Dear Supervisor Farrell:

Protect Our Benefits (POB) is a political action committee dedicated to protecting and enhancing the health benefits of retirees in the San Francisco Health Service System (HSS) and the pension benefits of retirees in the San Francisco Employees Retirement System (SFERS).

We are concerned about the Health Service System's decision to restrict health service plans to only two options for retirees, the United Health Preferred Provider Organization and Kaiser Hospital, both using Medicare Advantage.

For retirees to have only two plans restricts competition for service providers, enabling the raising of expenses for co-payments and premiums in the future. While this is not presently the case, there is no guarantee against this occurring in the future.

The two choices have different administrations, each having their own physicians and medical services. History has proven there is an advantage ~~in~~ having competitive plans. If either UHC or Kaiser raise their rates, the patient may be forced to change to only one available plan which may not meet his/her needs. And there is nothing to stop Kaiser and UHC from colluding to have the same rates for co-payments and premiums, as well as curtailing services such as chiropractors and acupuncture.

The City Plan is a Self Funded Plan administered by UHC. The City's affiliation with this plan has only been for one year. The newly accepted UHC MAPD PPO plan belongs to UHC and is a Fully Funded Insured plan which means the employer, the City, contracts with another organization to assume all financial risk for the enrollees' utilization of services and incurred administrative costs. It is not a City Plan.

Moreover, HSS through the UHC MAPD PPO plan has instituted a *"Second Opinion Benefit/Best Doctors"* adding over a million dollars annually to the rates. Second opinions, with a face-to-face visit with a doctor, are presently available to our members. This new benefit would not provide a visit to a doctor; but would be by phone or through the Internet with existing patient information. There is no proof that this newly added cost would benefit our members.

Presently, the City Health Plan covers doctors who do not take Medicare; and with more doctors opting out of Medicare, this is important for its beneficiaries. Members may be forced to change physicians posing a risk to the beneficiary's health.

On the basis of the above concerns, we are requesting further review and non-implementation of the Health Service System's recommendation at this time.

Respectfully,

Larry Barsetti
Chair, Protect Our Benefits

Cc: Members of Budget and Finance Committee
Catherine Dodd, Director of Health Service System

Wong, Linda (BOS)

rom: Board of Supervisors, (BOS)
Sent: Thursday, July 21, 2016 3:43 PM
To: BOS-Supervisors; Wong, Linda (BOS)
Subject: File 160747 FW: BOS Approval of HSS Rates Package - UHC Medicare Advantage PPO Plan
Attachments: Sass Letter supporting rates-benefits legislation.pdf

From: Scott, Laini (HSS)
Sent: Thursday, July 21, 2016 3:20 PM
To: Board of Supervisors, (BOS) <board.of.supervisors@sfgov.org>
Subject: BOS Approval of HSS Rates Package - UHC Medicare Advantage PPO Plan

Good Afternoon,

Please see the attached letter to Board President London Breed from Gregg Sass, Health Service Board Member, regarding legislation for BOS approval on July 26, 2016.

Thank you.

Laini K. Scott
Health Service Board Secretary
1145 Market Street, Suite 300
San Francisco, CA 94103
(415) 554-0662 – telephone
15) 554-1735 - fax
oard email: health.service.board@sfgov.org
Website: www.myhss.org

HEALTH SERVICE SYSTEM
CITY & COUNTY OF SAN FRANCISCO

3336 SCOTT STREET
SAN FRANCISCO, CA 94123

VIA EMAIL

July 21, 2016

Members of the Board of Supervisors

Subject: Approval of the fully-funded UHC Medicare Advantage PPO Plan

On Tuesday, July 26, you will be voting on the Rates and Benefit package approved by the Health Service Board and recommended by the BOS Budget and Finance Committee. Included in this legislation is a fully-funded UHC Medicare Advantage PPO Plan, which replaces the Blue Shield 65-Plus Plan and the Self-insured City Plan for Medicare retirees. I am writing this letter to encourage your approval of this Plan.

As a Health Service Board Commissioner, and former CFO for the Department of Public Health, (and former acting CFO for the Health Service System), I studied this issue thoroughly, and took time for a meeting with our AON actuary before voting to approve this Plan. I remain convinced that the Plan will provide broader geographic coverage at a lower cost than the plans it will replace.

I certainly understand the concerns of our retired members who worry about losing access to their physicians and hospitals. I too am a Medicare eligible retiree, and I will also be losing my Blue Shield coverage. I was also concerned about losing my access. However, I am satisfied that this will not be an issue. UHC presented data that indicates 94.5% of physicians already participate in this plan and those physicians currently provide 97.5% of services to patients.

In addition, there are no changes in covered services, member copays are lower, the coverage area is broader, and importantly, the total monthly cost of this plan is lower than the Blue Shield 65-Plus Plan, City Plan, and even the Kaiser Medicare Advantage Plan. And, as a fully-insured plan, there is no risk of underfunding that would require retention reserves required for self-insured plans.

Adoption of this Plan results in a 4.5% increase in cost to the overall Medicare population versus a 13.8% increase from continuation of the pre-existing plans. There is a two-year commitment that locks in rate increases in year two.

In terms of cost containment, it reduces the City's projected liability for post-employment retirement benefits.

I encourage the Members of the Board of Supervisors to support this plan. Please feel free to call me at (415) 602-1150 if you have any questions or concerns.

Sincerely,

Gregg Sass, Commissioner
Health Service Board