June 19, 2018

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

RE: January 1, 2019 to December 31, 2019 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 San Francisco Health Service System ("SFHSS") with regard to the completed rates and contribution setting process for the plan year from January 1, 2019 to December 31, 2019. This process was concluded on June 14, 2018 under the direction of the Rates and Benefits Committee ("Committee") of the Health Service Board ("HSB"). This report will reference attached exhibits, as well as tables embedded in this letter.

In our opinion, the 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 SFHSS' vendors' final rates and represent a fair price given the services provided, and;
- The premium equivalents set for the SFHSS self-funded and flex-funded programs—UnitedHealthcare ("UHC") City Plan, Blue Shield of California ("BSC") flex-funded Access+ and Trio plans, and Delta Dental of California ("Delta") PPO plan for active employees—represent our best estimate of future expenditures based on the information available at the time these rates were developed. Existing Trust Fund assets are expected to be sufficient to protect the SFHSS Trust Fund against adverse claims experience.

Legislative Update

The Patient Protection and Affordable Care Act (PPACA)

PPACA continues as law, and thus SFHSS continues to work 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 assure compliance with PPACA requirements continues. Some elements have been deferred indefinitely, such as the automatic enrollment requirement. Other provisions continue to be in effect. Following, you will find a brief explanation of the provisions that have the greatest effect.

Aon | Health & Benefits
425 Market Street | Suite 425 | San Francisco, California 94105
t: 415.486.7500 | f: 415.486.7026 | aon.com

PPACA Reporting Requirements

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

- Establish that the plan sponsor complied with PPACA's employer mandate by making an offer of affordable, minimum value health care coverage to its full-time employees (PPACA defines a full-time employee as an employee who is employed, on average, at least 30 hours of service per week, or 130 hours of service in a calendar month.)
- Provide individuals with information on their employer-provided health care coverage so they can establish compliance with the individual mandate to purchase health care coverage
- Help the IRS determine whether individuals who have purchased coverage from a public exchange are entitled to a subsidy and
- Help the IRS determine applicable penalties for failure to comply with the individual mandate

Reporting started in 2016 with 2015 calendar year information on Forms 1094 and 1095, and remains an annual requirement.SFHSS successfully met this requirement for the past three years by sending about 51,000 IRS forms each year to employees and electronically reporting to the IRS.

PPACA Legislative Fees

In 2010, the Patient Protection and Affordable Care Act (PPACA) created a Health Insurance Tax and two direct fees which are passed to employers (one of which expired after 2016—transitional reinsurance fee). The PPACA 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 is a brief explanation of the fees which applied in 2018, as well as commentary on why they do not apply in 2019 to SFHSS health plans.

- Health Insurance Tax (HIT): This tax impacts all fully insured health plans offered through SFHSS, including dental and vision plans. As was noted at the March 9, 2017 HSB meeting, BSC requested a review by the California Department of Managed Health Care (“DMHC”) as to the insured status of the flex-funded plan. The California DMHC determined that the BSC flex-funded plan is not considered “insured” and thus the HIT would not apply to this plan. There is a one-year moratorium on this fee for plan year 2019, and therefore it is not included in the rates presented in this letter. The HIT did apply in the 2018 plan year.
- Patient Centered Outcomes Research Institute (PCORI) Fee: This fee commenced during the 2012 plan year with the first payment made by SFHSS by July 31, 2013. The final annual PCORI fee of $2.39 per covered life in any medical plan applies to SFHSS’s 2018 plan year to be paid by July 31, 2019. With PCORI fee obligations expiring after 2018 for calendar year plans, no PCORI fee obligation will accrue for SFHSS in calendar year 2019. The fee is collected by the IRS.

Therefore, there are no Federal ACA fees in 2019 rates for any SFHSS plan.

Other Legislative Fees—California Managed Care Organization Tax

There is a California state Managed Care Organization (MCO) tax that applies to the BSC Access+ and Trio plans during the 2019 plan year. This MCO tax was enacted by California Senate Bill X2-2 (Hernandez, Chapter 2, Statutes 2016) effective for a taxing period July 1, 2016 through June 30, 2019. This fee is $1.30 per covered life per month during 2019 for the BSC plans offered by SFHSS. The MCO tax obligation in 2019 that is paid to BSC in fixed fees is expected to be $591,000 for all four employers—including City and County of San Francisco (CCSF)-only portion of $504,000.

Contributions under the 10-County Survey

Per City Charter Section A8.428, the employer contribution towards medical benefits is determined by the results of a survey of the dollar premium contributions provided by the ten most populous counties in California, excluding San Francisco. In the June 2014 CCSF collective bargaining process, the 10-County Survey ("Survey") was eliminated for the majority of the CCSF unions in the calculation of premium contributions for active employees in exchange for a percentage-based employee premium contribution. The Survey remains in use as a basis for calculating retiree premium contributions. For the 2019 plan year, the Survey, based on 2018 rates, determined the average monthly contribution increased 3.53% from $649.17 to $672.08. The full Survey report is contained as an Appendix to this letter, and was presented at the March 8, 2018 HSB meeting. It is also accessible at myhss.org.

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

Annual aggregated costs for all medical plans offered by SFHSS (through UHC, Kaiser, and BSC) to active employees, early retirees, and Medicare retirees are shown in Table 1 below.

Table 1

January 1, 2019 to December 31, 2019 Aggregate Medical Plans Cost ($ millions)

	Aggregate Member Contributions (a)	Aggregate Employer Contributions (b)	Aggregate Plan Cost (a + b)
Current (2018) Rates	**$93.4**	**$742.4**	**$835.8**
Final Renewal (2019) Rates	**$97.5**	**$759.5**	**$857.0**
$ Difference	$4.2	$17.1	$21.2
% Difference	4.50%	2.30%	2.54%

Per Table 1 above, we expect an increase in aggregate plan costs totaling $21.2 million, or 2.54%, for the SFHSS medical plans (including core vision coverage, the Best Doctors second opinion service fees, and the SFHSS Healthcare Sustainability Fund expense) for the 2019 plan year. This increase in costs will be split 19.8% / 80.2% between the members and employers with member contributions increasing $4.2 million and employer contributions increasing $17.1 million. These changes are based on current June 2018 enrollment.

Current CCSF Health Plan Employer Contribution Strategy—Active Employees

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

1) 93/93/83 Contribution Model:

- **a)** Employee Only: For single-covered employees (Employee Only) who enroll in any health plan offered through the San Francisco Health Service System (SFHSS), CCSF shall contribute ninety-three percent (93%) of the total health insurance premium/premium equivalent provided. However, CCSF's contribution shall be capped at ninety-three percent (93%) of the Employee Only premium/premium equivalent of the second-highest-cost plan.
- **b)** Employee Plus One: For employees with one dependent who elect to enroll in any health plan offered through SFHSS, CCSF shall contribute ninety-three percent (93%) of the total health insurance premium/premium equivalent provided. However, 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 SFHSS, 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 SFHSS, CCSF shall contribute one hundred percent (100%) of the total health insurance premium/premium equivalent.
- **b)** Employee Plus One: For employees with one dependent who elect to enroll in any health plan offered through SFHSS, CCSF shall contribute ninety-six percent (96%) of the total health insurance premium/premium equivalent provided. However, 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 SFHSS, 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 2019. One rate card specified member contributions under the 93/93/83 model and the other rate card under the100/96/83 model.

Current CCSF Health Plan Employer Contribution Strategy—Retirees

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

- 10-County Survey amount: This first component of the employer contribution is the amount derived from the annual survey described in Charter Section A8.423 of contributions provided by the 10 most populous counties in CA, not including San Francisco—called the "average contribution". The 2019 10-County amount is $672.08. If the total cost for Retiree Only for a plan is less than the 10-County Amount, that lower amount becomes the basis for that plan for the 10-County employer contribution portion.
- "Actuarial Difference": The second employer contribution component is the "actuarial difference" for a given plan. Under Charter Section A8.428(b)(3), the employers contribute the difference between Active Employee-Only premium and Early Retiree-Only premium.
- Prop. E Contribution: The third employer contribution component is the Prop. E contribution amount. Under Charter Section A8.428(b)(3)(iii) and A8.428(c), employer contributions toward Retiree Only and Retiree +1 rates = 50% x [Total Rate Cost – 10-County Amount – "Actuarial Difference"].

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

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

Outline of 2019 Health Plan Design and Rating Actions

Below we describe the plan design changes and rating actions that apply to each SFHSS health plan for the 2019 plan year, based on approval actions taken during the recently completed Rates and Benefits cycle by the HSB.

Kaiser Permanente (Fully Insured) for All Four Employers

The final negotiated rate change for Kaiser Permanente ("Kaiser") active employees, early retirees, and Medicare retirees is an overall decrease of 2.17% for plan year 2019. This overall average is primarily generated by a 0.3% premium rate reduction for active employees and early retirees in California, and a 13.0% premium rate reduction for Medicare retirees in California. There are also small retiree populations with Kaiser HMO coverage in the Northwest (Oregon), Washington, and Hawaii regions captured in the overall average Kaiser rating action. The HIT suspension for 2019 as documented earlier in this letter was a key factor in the rating reductions into the 2019 plan year for Kaiser plans.

This results in an overall estimated decrease of $9.2 million annually for all four employers based on June 2018 membership of which $6.8 million is attributed to CCSF and $2.4 million is attributed to the other employer groups (e.g., CRT, USD, and CCD).

The aggregate cost for Kaiser Permanente for the 2019 plan year is projected at $415.8 million, with $43.6 million in member contributions and $372.2 million in employer contributions. Table 3 (page 12) provides an overview of annualized costs.

The 2019 Kaiser plan rates are illustrated in exhibits 2a-2e in the adjoining document.

Blue Shield of California (Flex-funded) for All Four Employers

The Trio flex-funded plan was introduced as a second BSC plan option for active employees and early retirees for the 2018 plan year. As a result of BSC renewal inputs and Aon's underwriting process, we are projecting increases of 10.5% for BSC Access+ total cost rates and 5.6% for Trio total cost rates into the 2019 plan year. No plan design changes are planned for 2019.

Overall, this produces an aggregate increase of 8.71% for the combination of the two BSC flex-funded HMO plans into the 2019 plan year. Approximately 60% of BSC enrolled active employees/ early retirees remained in Access+ in 2018, versus about 40% migrating to the new Trio plan.

The aggregate 2019 projected cost for all four employers in the BSC Access+ and Trio plans is $331.5 million, with $37.0 million in member contributions and $294.5 million in employer contributions based on June 2018 membership. This results in an overall estimated increase of $26.6 million annually for all four employers based on June 2018 membership of which $23.6 million of the increase is attributed to CCSF and the remaining $3.0 million is attributed to the other employer groups (e.g., CRT, USD, and CCD). Table 3 (page 12) provides an overview of annualized costs.

The 2019 BSC flex-funded HMO plan rates are illustrated in exhibits 3a-3b for HMO Access+ and 3c-3d for Trio in the adjoining document.

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

The City Plan is a self-funded medical plan administered by UnitedHealthcare (UHC) for active employees and early retirees. The medical and pharmacy monthly premium equivalent costs were developed separately for actives and retirees without Medicare based on group-specific experience. Additionally, Aon provided to the HSB 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 to determine the premium equivalent levels for the 2019 plan year.

A major factor in the active and early retiree total premium equivalent increases for the 2019 calendar year is the reduction in available funds in the City Plan rate stabilization reserve. At the end of 2014, there was $25.8 million available in the City Plan rate stabilization reserve. These amounts were applied to City Plan rating beyond the HSB Self-Funded Plans' Stabilization Policy of one-third application in 2016, 2017, and 2018 plan year rating. As of December 31, 2017, there was $1,661,000 remaining in the City Plan rate stabilization reserve fund. Per the HSB decision at the June 14 meeting, this full amount will apply into 2019 City Plan rating—noting this is significantly less than amounts applied in recent years (including $4,529,000 for the 2018 plan year).

The UHC base administration fee increased 2.7% from 2018 to 2019. An additional amount of $0.71 per covered employee/retiree per month is built into the 2019 administrative fee, but will be more than offset by a negotiated reduction in the percentage of claim savings that UHC will keep for certain out-of-network services where UHC has negotiated a secondary discount (called the Shared Savings Program).

Five changes were approved by the Rates and Benefits Committee and HSB for 2019 City Plan:

- A new plan, "City Plan—Choice Not Available", was approved to provide lower member contributions for those who lack geographic access to other plans offered by BSC and Kaiser (this is projected to apply to 73 active employees and 436 early retirees);
- A UHC California provider re-contracting initiative will result in increased average discounts for provider services from the current contract, without any change in the provider composition of UHC's PPO network;
- An increase to member-paid prescription drug copayments to match those in BSC Access+ and Trio plans;
- An increase to member-paid out-of-network deductibles (currently same as in-network); and
- A year one of three change to balance rate tier ratios for City Plan early retirees to be consistent with family tier ratios for BSC early retiree plans over the next three renewal cycles (2019-2021), thus helping to moderate contribution requirements for City Plan early retiree families.

As a result of the underwriting adjustments, change in Rate Stabilization Reserve amounts, and impact of the five changes outlined above, the overall total premium equivalent increases for the City Plan into the 2019 plan year are 19.3% for active employees and 4.4% for early retirees.

As of January 1, 2017 all Non-Kaiser Medicare eligible retirees became covered under the UHC fully insured Medicare Advantage PPO Plan (which was previously branded as the "New City Plan"). In 2019, the premiums for this Medicare plan will decrease 0.7%. This includes the following plan changes approved by the Rates and Benefits Committee and the HSB:

- A new preferred diabetic supplies program that allows for reduced member copayments for kidney dialysis, urgent care, and certain therapy services;
- A change to the prescription drug formulary to better align with Medicare standards; and
- Post-discharge meal delivery, care-related transportation, and nutritional counseling benefits.

The aggregate 2019 cost for the UHC plans across active employees, early retirees, and Medicare retirees is projected at $109.7 million, with $16.9 million in member contributions and $92.8 million in employer contributions. This results in an overall estimated increase of $3.9 million annually for all four employers based on June 2018 enrollment; of which $3.5 million is attributed to CCSF and $0.4 million is attributed to the other employer groups (e.g., CRT, USD, and CCD). Table 3 (page 12) provides an overview of annualized costs.

The 2019 UHC plan rates are illustrated in exhibits 4a-4b for City Plan/Medicare Advantage plans, and in exhibits 4c-4d for City Plan—Choice Not Available/Medicare Advantage plans in the adjoining document.

Rates and Benefits for the Vision Plan for All Four Employers

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

There is also a buy-up Premier Plan available to SFHSS members. This second vision plan was first offered for the 2018 plan year. In 2018, VSP administered the enrollment in the Premier Plan. For 2019, SFHSS will administer the enrollment in the Premier Plan. This results in lower member contributions for the Premier Plan by $1.50 per month for all coverage tiers into the 2019 plan year.

Based on June 2018 enrollment, the aggregate projected 2019 employer cost for the VSP vision plan is $5.2 million. The employer portion of vision plan costs will remain constant from 2018 to 2019, as the Basic Plan premiums are not changing from 2018 to 2019. VSP vision plan costs for all four employers are illustrated in Exhibits 5a-5b in the adjoining document.

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

Three dental plans are offered to SFHSS active employees: Delta Dental PPO, DeltaCare USA HMO, and UnitedHealthcare Dental HMO. The Delta Dental PPO plan has a network of preferred providers while the other two plans are dental HMOs with closed panels of providers. The City pays part of the cost of dental benefits for active CCSF employees while retirees pay the full cost of their dental plans.

The Delta Dental PPO plan for active employees is self-funded and administered by Delta Dental of California (Delta Dental). Future plan costs are projected based on the City employees' claim experience. Delta Dental's administrative fee is increasing from $4.35 per employee per month to $4.62 per employee per month into 2019 (an increase of 6.2%), with the administrative fee now guaranteed through December 31, 2021. A portion of this increase ($0.10 per employee per month) is attributable to a benefit enhancement (the SmileWay program, described below) and implementation of a cost estimator cost tool to benefit members in evaluating the costs for certain dental services.

Five enhancements were approved by the Rates and Benefits Committee and HSB for 2019 Delta Dental active employee PPO plan:

- SmileWay Program: Allows members with specific chronic conditions (diabetes, heart disease, HIV/AIDS, rheumatoid arthritis, or stroke) to receive an annual periodontal scaling and root planing procedure as well as more frequent teeth cleaning/periodontal maintenance services;
- Cost Estimator Tool: Provides members the ability to model the estimated cost of specific services in advance and will suggest as an option, alternative, less-costly providers;
- Accident Benefit Rider: Additional coverage for dental services for conditions caused directly or independently of all other causes by external, violent, and accidental means;
- Adult orthodontic lifetime maximum increases by $1,000 in each provider tier category (to match child orthodontia maximum levels); and
- Remove 6-month waiting period for prosthodontic and orthodontic coverage.

Due to the combination of recent favorable experience in the active employee Dental PPO plan and availability of rate stabilization reserve balance funds, even after consideration of the benefit enhancements above, the aggregate premium equivalents for the self-funded Delta Dental PPO plan for active employees are decreasing 4.1% decrease for plan year 2019.

The Delta Dental PPO plan for retirees, DeltaCare USA dental plans for active employees and retirees, and UnitedHealthcare Dental plans for active employees and retirees are all fully insured. All dental plan fully insured rates will remain the same as in 2018 for the 2019 plan year—and the Delta Retiree PPO and DeltaCare USA plan rates are now guaranteed through December 31, 2021. The Delta Retiree PPO plan will also include the SmileWay benefit for the first time in 2019.

For the 2019 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 for the Employee Only tier, $10.00 for the Employee +1 tier, and $15.00 for the Employee +2+ tier. The member contributions for Delta Dental PPO plan for retirees and DeltaCare USA dental plans for actives and retirees, and UnitedHealthcare Dental plans for actives and retirees remain unchanged from the 2018 plan year. Pursuant to the Health Service Board's Self-Funded Plans' Stabilization Policy, a claims stabilization amount of $4.2 million has been applied for 2019 towards the self-funded Delta Active PPO plan.

The 2019 dental plan rates are shown in the adjoining document for the Delta Dental PPO (Exhibits 6a-6b), DeltaCare USA HMO (Exhibits 7a-7b), and UHC Dental HMO (Exhibits 8a-8b).

The aggregate dental plan cost for active employees for the 2019 plan year is projected at $46.5 million with $3.7 million in member contributions and $42.7 million in employer contributions. This results in an overall estimated decrease of $1.9 million annually for all four employers based on June 2018 enrollment. There is a slight decrease 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), supplemental life insurance (member paid), and long-term disability insurance (employer and employee paid) premiums remain unchanged and are guaranteed through December 31, 2019. In late 2017, the Hartford Life and Accident Insurance Company acquired the group life and disability business of Aetna Group Insurance—thus, Hartford is the insuring entity for the SFHSS life and disability insurance plans going forward.

The aggregate basic life insurance and LTD plan cost for the 2019 plan year is projected at $8.40 million. This includes $7.34 million in total LTD premiums and $1.06 million in basic life premiums. Additionally, there is $0.96 million in projected member-paid 2019 supplemental life insurance premium. Annualized overall premiums are shown in Exhibit 9 in the adjoining document.

Medical Second Opinion Benefit for All Four Employers and All Retirees

Best Doctors is a second opinion service that started during the 2017 plan year with a guaranteed rate of $1.40 per employee/retiree per month through December 31, 2019 for all SFHSS health plans. As a result of recently completed negotiations, the 2019 rate for the Best Doctors service has been lowered to $1.15 per employee/retiree 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 2019 Plan Year Costs

Table 3 below summarizes projected 2019 aggregate SFHSS plan costs across the plans available to active employees and retirees relative to 2018 projections for those plans where the employers subsidize the total plan cost. VSP Basic Plan (vision) costs are included in the medical plans' costs.

TABLE 3—ALL FOUR EMPLOYERS *					
Distribution of Aggregate 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 **	**$43.6**	**$372.2**	**$415.8**	**10.50%**	**89.50%**
$ Change	-$1.1	-$8.1	-$9.2		
% Change	-2.43%	-2.14%	-2.17%		
BSC HMOs **	**$37.0**	**$294.5**	**$331.5**	**11.16%**	**88.84%**
$ Change	+$3.4	+$23.2	+$26.6		
% Change	+10.03%	+8.55%	+8.71%		
UHC Plans **	**$16.9**	**$92.8**	**$109.7**	**15.41%**	**84.59%**
$ Change	+$1.9	+$2.0	+$3.9		
% Change	+12.54%	+2.19%	+3.66%		
Dental ***	**$3.7**	**$42.7**	**$46.5**	**8.06%**	**91.94%**
$ Change	$0.0	-$1.9	-$1.9		
% Change	0.00%	-4.35%	-4.01%		
LTD Insurance	**$0.0**	**$7.3**	**$7.3**	**0.00%**	**100.00%**
$ Change	$0.0	$0.0	$0.0		
% Change	0.00%	0.00%	0.00%		
Life Insurance	**$1.0**	**$1.1**	**$2.0**	**47.43%**	**52.57%**
$ Change	$0.0	$0.0	$0.0		
% Change	0.00%	0.00%	0.00%		
Total	**$102.3**	**$810.6**	**$912.9**	**11.20%**	**88.80%**
$ Change	+$4.2	+$15.1	+$19.3		
% Change	+4.25%	+1.90%	+2.16%		

** Figures vary due to rounding*

*** Includes $1.15 PEPM for Best Doctors second opinion service*

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

This year's projected aggregate medical cost increase of 2.54% (see page 4) compares favorably with available benchmark information. The "2018 Health Care Trend Survey" published by Aon indicates combined medical/pharmacy cost increases in the range of 5% to 6%.

Conclusion

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

Sincerely,

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

cc: President and Members of the Health Service Board
Abbie Yant, San Francisco Health Service System

Appendix

Table 3A: City and County of San Francisco (CCSF)

TABLE 3A–CCSF ONLY *					
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 **	**$35.0**	**$289.9**	**$324.9**	**10.78%**	**89.22%**
$ Change	-$0.9	-$6.0	-$6.8		
% Change	-2.38%	-2.02%	-2.06%		
BSC HMOs **	**$32.9**	**$258.1**	**$291.0**	**11.31%**	**88.69%**
$ Change	+$3.0	+$20.6	+$23.6		
% Change	+10.12%	+8.66%	+8.82%		
UHC Plans **	**$14.3**	**$74.3**	**$88.6**	**16.14%**	**83.86%**
$ Change	+$1.6	+$1.9	+$3.5		
% Change	+12.37%	+2.66%	+4.11%		
Dental ***	**$3.7**	**$42.2**	**$45.9**	**8.06%**	**91.94%**
$ Change	$0.0	-$1.9	-$1.9		
% Change	0.00%	-4.35%	-4.01%		
LTD Insurance	**$0.0**	**$7.3**	**$7.3**	**0.00%**	**100.00%**
$ Change	$0.0	$0.0	$0.0		
% Change	0.00%	0.00%	0.00%		
Life Insurance	**$1.0**	**$1.1**	**$2.0**	**47.43%**	**52.57%**
$ Change	$0.0	$0.0	$0.0		
% Change	0.00%	0.00%	0.00%		
Total	**$86.9**	**$672.8**	**$759.7**	**11.44%**	**88.56%**
$ Change	+$3.7	+$14.6	+$18.3		
% Change	+4.50%	+2.22%	+2.47%		

** Figures vary due to rounding*

*** Includes $1.15 PEPM for Best Doctors second opinion service*

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