San Francisco Health Service System Health Service Board Finance and Budget Sub-Committee

Non-Medicare Health Plan Rating Methodology

February 13, 2020

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Health Solutions

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Contents—Non-Medicare Health Plan Rating Methodology

- Calculation methodology for San Francisco Health Service System (SFHSS) health care plan "total cost rates" calculations
  - Self-funded/flex-funded plan rates: developed by Aon
  - Fully insured plan rates: developed by health plans
- Setting employer and member health plan contributions
- Next steps in rating methodology—assessing health plan rate relationships across SFHSS-provided non-Medicare plans and dependent coverage tiers (historical context and current state)

Calculation Methodology—Total Cost Rates

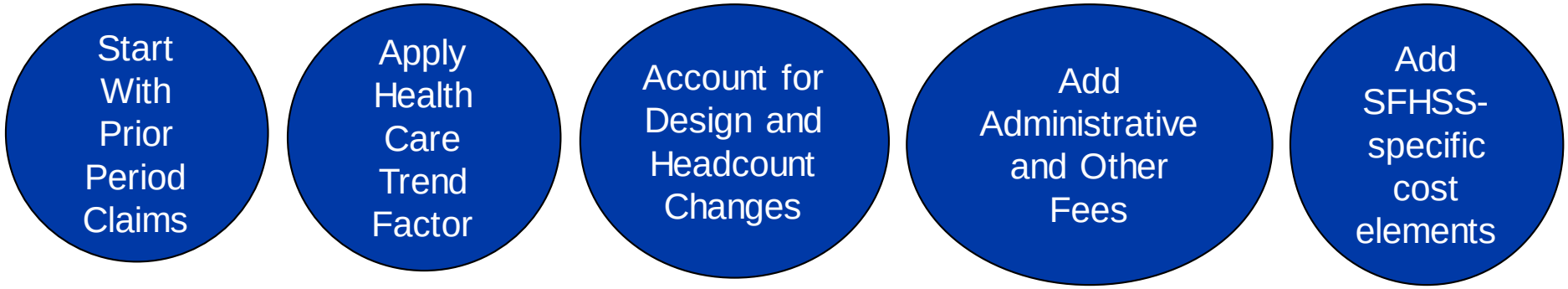
Self-Funded Plan Total Rates—Calculation Methodology

- Aon calculates total cost rates annually for all San Francisco Health Service System (SFHSS) **self-funded** and **flex-funded** medical and dental plans
  - UnitedHealthcare (UHC) PPO "City Plan" (active employees and early retirees)
  - Blue Shield of California (BSC) Access+ and Trio Plans (active employees and early retirees)
  - Delta Dental of California Active Employee PPO Plan
- All other plans not listed above that are offered through SFHSS are **fully insured**, and thus total premium rates are developed by the health plans
  - All Kaiser Permanente (Kaiser) plans for active employees and retirees
  - UHC Medicare Advantage PPO plan
  - All dental plans other than the Active Employee PPO Plan
  - VSP vision plans

Self-Funded Plan Total Rates—Calculation Methodology

Forecasting Projection Period Costs

- Self-funded plan rate development premise: utilize recent claim experience to project best estimate for projection period incurred claims, then add applicable fees to calculate projection period plan rates



Projection Period Rates by Plan and Tier

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Self-Funded Plan Total Rates—Step #1

Start With Prior Period Claims

Start with Prior Period Claim Experience

- Claim experience utilized in SFHSS rate projection calculations is from the most recently completed **calendar year** for initial projections
  - Aon may incorporate first quarter data from the current calendar year **IF** substantial plan changes and/or enrollment shifts occurred into present year
  - Aon matches claims incurred in experience period to covered headcounts for the same period → this forms the basis of the experience used in the projections
    - "Incurred date" = date health care service occurred
    - Aon uses separate claims/headcounts for active employees versus early retirees for medical/Rx plan rate projection processes

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Self-Funded Plan Total Rates—Step #2

Apply Health Care Trend Factor

Apply Health Care Cost Inflation "Trend" in Forecast Calculations

- Health care claim trend factors are determined using SFHSS plan-specific experience and applied on a "midpoint-to-midpoint" basis between experience and projection periods
  - For BSC plans, BSC develops the medical/Rx/admin trend factor which is subject to SFHSS/Aon review and negotiation
  - For UHC City Plan and Delta Dental active employee PPO, Aon develops trend factor recommendations using a combination of statistical regression on SFHSS rolling 6-to-24 month time periods and national trend factors
- Claim costs in the rating projections also include provision for prescription drug rebates in the medical plans, as well as capitation and large claim pooling adjustment in the BSC plans
  - "Capitation" is a fixed cost for a set of certain services within the BSC ACO plans, including costs for primary care services

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Self-Funded Plan Total Rates—Step #3

Account for Design and Headcount Changes

Adjusting Forecast for Plan Design and Headcount Changes

- The actuarial value of any plan design changes that have occurred from the prior claim experience period and projection period should be accounted for in the rate projection calculation
- Changes in enrollment by plan and tier between claim experience period and current should also be incorporated into the health care rate projection calculations
- Aon may also incorporate significant changes in overall health risk and/or demographic composition of a plan's enrolled population from prior period to current period in this step, though historically SFHSS health risk and demographic profiles within a given plan have remained relatively steady

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Self-Funded Plan Total Rates—Step #4

Add Administrative and Other Fees

Health Plan Administrative Fees

- Administrative fees are included in calculated plan rates
  - BSC: administrative fees and large claim pooling fees are included into the total health plan costs shown in BSC plan rate cards
  - UHC: fees in rate card include base administrative (ASO) fee, as well as components for Shared Savings, Facility Reasonable & Customary, and Value-Based Pricing programs
  - Delta Dental Active PPO: ASO fees included with claims projection in final rate calculation
- Legislative fees are also included where applicable

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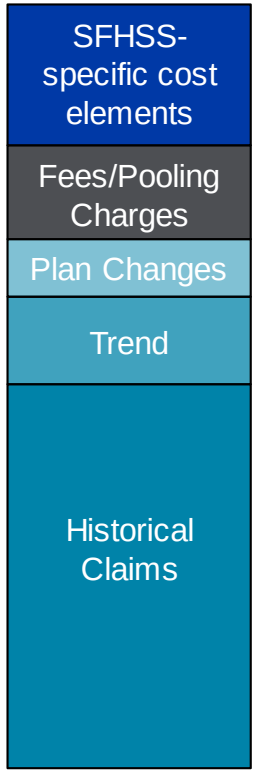
Self-Funded Plan Total Rates—Step #5

Add SFHSS-specific cost elements

Other SFHSS-Specific Cost Elements in Health Care Rates

- All SFHSS self-funded and flex-funded total plan rates include provision for **Claim Stabilization Reserve** change adjustments based on SFHSS policy
  - Amounts to apply in rating each year for each self-funded/ flex-funded plan are determined in the February through April timeframe based on prior plan year experience relative to original forecasts
  - Resulting amounts utilized in total rate setting formulas for the projection period become, per policy, a one-third amortization of claim stabilization reserve balances for each plan as of December 31 of the prior year (deviations from policy can occur with Health Service Board [HSB] approval)
- Medical plan total cost rates also include:
  - SFHSS Health Care Sustainability Fund Charge (currently $3 per month which applies across each coverage tier)
  - Basic VSP vision insured plan rates (vary by coverage tier)



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Self-Funded Plan Total Rates—Calculation Methodology

Allocating Projection Period Costs Into Plan/Tier Rates

- Once projection period cost estimates are developed, self-funded/flex-funded total plan cost rates are generated for the projection period utilizing existing "rate ratios" for the **three dependent coverage tiers** for each plan:
  1. Employee/Retiree Only (e.g., EE/RET Only)
  2. Employee/Retiree Plus One Dependent (e.g., EE/RET + 1)
  3. Employee/Retiree Plus Two or More Dependents (e.g., EE/RET + 2+)
- A "rate ratio" is the mathematical difference relative to the EE/RET Only rate, when dividing a dependent tier rate by the EE/RET Only rate—here is an example:

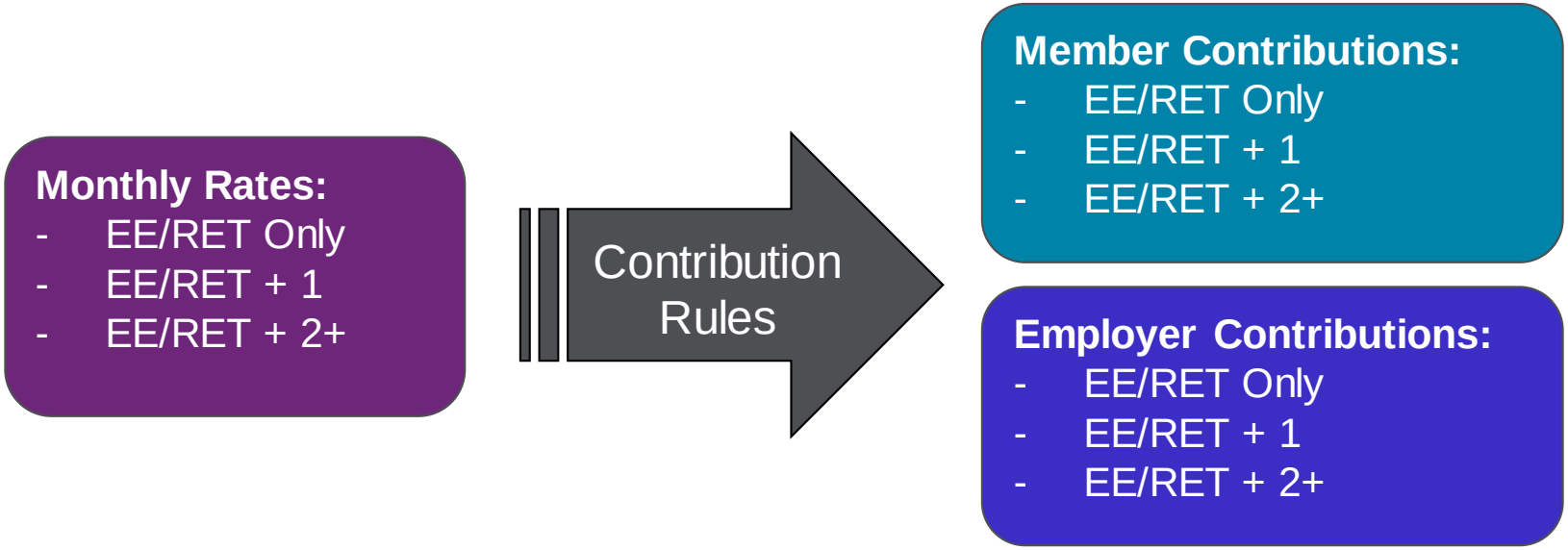
Tier	Monthly Rate	Rate Ratio to EE Only
EE Only	$100	1.00
EE + 1 Dep	$220	2.20
EE + 2+ Deps	$350	3.50

Self-Funded Plan Total Rates—Calculation Methodology

Allocating Projection Period Costs Into Plan/Tier Rates

- All of the elements of premium/budget rate projections discussed on earlier pages creates a total expected cost for the health plan in the projection period—rate ratios are then used to allocate these expected costs into rates by each of the **three dependent coverage tiers** as shown below
- Retiree tiers are further delineated for "split families"—where one or more family members of a retiree family are not yet Medicare eligible, and one or more family members is Medicare eligible

Setting Employer and Member Contributions



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Health Plan Contributions—Methodology

Active Employees (City/County Employer)

- Medical plan employer contributions are based on negotiated percentages by dependent coverage tier (100/96/83 and 93/93/83) for most plans
  - For medical/Rx/vision, the employer contribution dollar amounts for the most expensive plan (UHC "City Plan" PPO) are same as those for second most expensive plan (BSC Access+)
  - Medical employer and employee contributions for other employers participating in SFHSS health plans are based on contribution agreements for those employers with its employees
- For dental plans, CCSF employees pay $5/$10/$15 per month for Delta Dental PPO and pay no contributions for the two dental HMOs
  - SFHSS does not provide dental plan coverage for SFUSD and City Colleges
- Employees pay the full cost increment for the VSP Premier Plan ("buy-up" plan), relative to the premium for the VSP Basic plan

Health Plan Contributions—Methodology

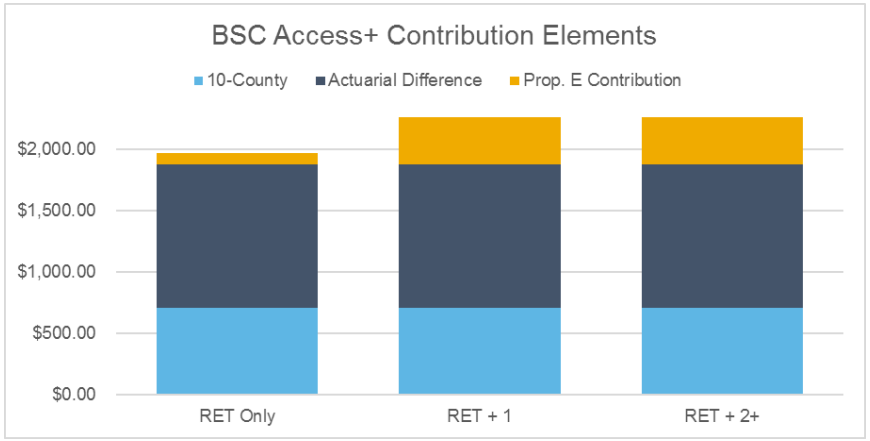
Retirees

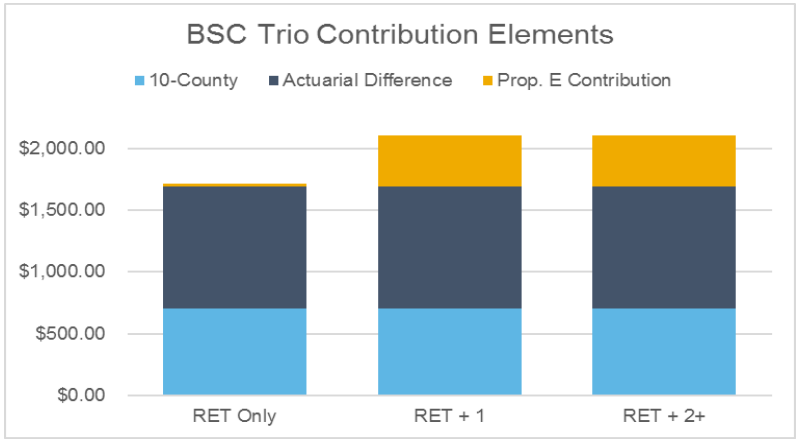
- Retirees hired on or before January 9, 2009: **medical/Rx/vision plan employer contribution amounts** are based on three components as defined in the **City Charter**—two of which are developed separately for each plan
  - **Element that is same for all plans:** 10-County amount (single tier retiree amount cascades to dependent tiers)
  - **First element that varies for each plan:** "Actuarial difference" which is the difference between single tier premiums for active employees and early retirees for a given plan (single retiree amount cascades to dependent tiers)
  - **Second element that varies for each plan:** Retiree Prop. E contribution which is 50% times [total cost rate cost, less 10-County amount, less "Actuarial Difference"]—performed for both Retiree Only tier and Retiree + 1 tier (then Retiree + 1 tier amount cascades to Retiree + 2+ tier)
- Plan-specific charts on following pages illustrate early retiree employer contribution components for each dependent coverage tier

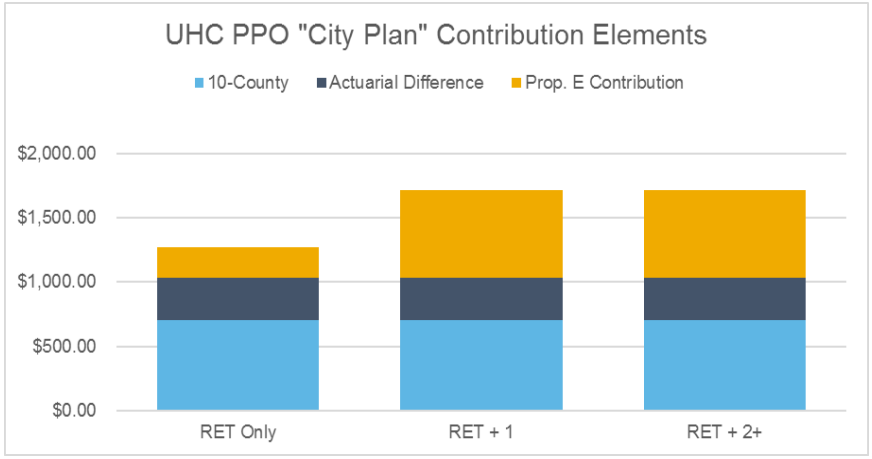
Health Plan Contributions—Methodology

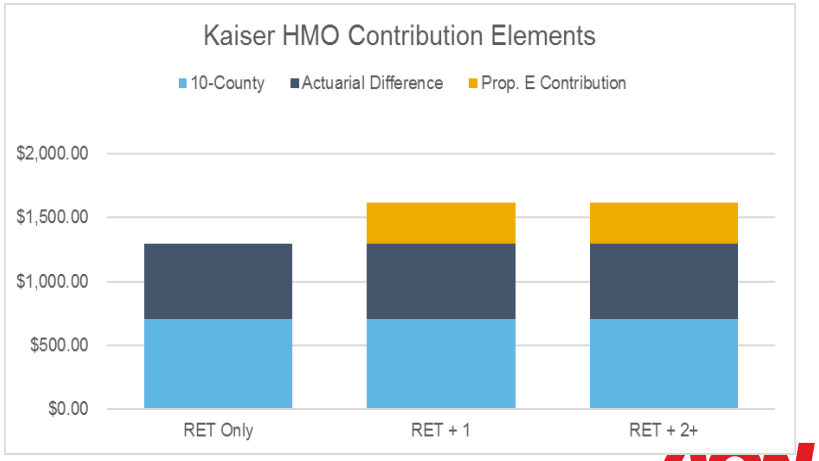
Early Retirees—2020 Employer Contribution Components

- 10-County Amount same for all plans, other elements differ by plan









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Health Plan Contributions—Methodology

Retirees (continued)

- Employer contributions are limited to be no more than the cost of Retiree Only coverage—this applies in 2020 for the following plans:
  - Kaiser HMO for early retirees
  - Kaiser Permanente Senior Advantage (KPSA) for Medicare retirees
  - UHC Medicare Advantage (MA) PPO for Medicare retirees

Health Plan Contributions—Methodology

Retirees (continued)

- Retirees hired on or after January 10, 2009: medical/Rx/vision employer contributions vary by years of service:
  - At least 5 but less than 10 years of service: no employer contribution (coverage is fully paid by retiree)
  - At least 10 but less than 15 years of service: 50% of the employer contribution amounts provided to retirees hired on or before January 9, 2009
  - At least 15 but less than 20 years of service: 75% of the employer contribution amounts provided to retirees hired on or before January 9, 2009
  - At least 20 years of service: the same employer contribution amounts as those provided to retirees hired on or before January 9, 2009
- Dental coverage is fully contributory (no employer contribution) for all retirees, as is the full increment of the VSP vision Premier Plan cost beyond the Core plan insured rate

Next Steps in Rating Methodology Discussion

Next Steps in Rating Methodology Discussion

Review Historical Context and Current State in Non-Medicare Plan Rating

- Review why rate ratios across dependent coverage tiers vary across SFHSS-offered plans
- Discuss how that impacts what active employees and early retirees pay for their member contributions today
- Understand the impact each of the employer contribution portions of the City Charter has on what members pay in contributions for a given health plan