Health Service Board
Annual Rates and Benefits (R&B) Process and Cycle

January 9, 2025

Agenda

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Duties and Responsibilities

Under the San Francisco City Charter section A8.422, the Health Service Board (HSB) plays an important role in designing health benefit plans for members covered through the San Francisco Health Service System (SFHSS).

HSB duties include:

- adopting plan(s) for rendering medical care to SFHSS members; and
- designing benefit plans and benefit changes to SFHSS members
  - Health (medical/Rx), Dental, Vision, Life Insurance, and Long-Term Disability (LTD)

The full HSB meets as a Committee of the Whole to review and approve the rates and benefits. The annual benefits and rate setting process will guide the HSB to approve all health plans for the following calendar year.

Rates and Benefits Cycle Timeline

- January-Release Rates and Benefits Calendar for following plan year; prior fiscal year-end Incurred But Not Reported (IBNR) and Contingency reserves approved
- February through June-HSB reviews and approves next plan year's health plans and rates for actives and retirees including health, dental, vision, life insurance, and LTD
- July-Rates and Benefits package reviewed by the Board of Supervisors (BOS) Budget and Finance Committee, then confirmed by the full BOS
- July through August-Renewal confirmation letters signed by health plans; SFHSS system programming for Open Enrollment commences
- September-SFHSS mails Open Enrollment packets to members containing information about benefits, rates, and new offerings. SFHSS presents annual benefits contract market evaluation and assessment to determine RFP or RFI for following plan year
- October-Open Enrollment (when SFHSS members can make changes to their health plan enrollments for the following plan year)
- December-SFHSS confirm membership selections that will be effective January 1

SFHSS Annual Benefit Contracts Market Evaluation and Assessment

The SFHSS Contracts Division reports on the status of contracts under SFHSS jurisdiction each year. In August/September, SFHSS informs the HSB of any planned Request For Proposal (RFP) and/or Request For Information (RFI) for primary service providers.

- Competitive procurement via a Request for Proposal (RFP):
  - Formal proposal with required financial commitments (rates, fees, premiums);
  - Runs concurrent with the annual renewal process for incumbent plan administrator(s);
  - SFHSS presents results and recommendation to the HSB for review and final approval;
  - Approval required prior to submission of annual rates and benefits package to BOS.
- Request for Information (RFI):
  - Broad/forward-looking scope, voluntary financial commitments and no contract awarded.
  - May be conducted as a market assessments or to narrow the scope and/or determine the timing of a future RFP.

R&B Process Starts With Reserve Approvals

The HSB has funding policies to ensure the financial health and adequacy of the funding needs for the benefits—including three distinct health plan reserve policies:

1. Incurred But Not Reported (IBNR) (HSB review and approval in January): Actuarial estimate of the unpaid liability for run-out claims where services were incurred on or before a given date, but those claims have not yet been paid as of that date; calculated annually as of June 30 (last day of fiscal year) for SFHSS plans;
2. Contingency (HSB review and approval in January): Statistically determined amount which protects against potential for funding estimate shortfalls which could occur when the actual claims incurred over a plan year would exceed projected claims when developing premium equivalents; and
3. Rate Stabilization (HSB review and approval in March/April): Annual determination of the financial gain or loss for the self-funded/flex-funded plans.

Funding Types for SFHSS Health Benefits

SFHSS health plans utilize three different funding types, which vary by plan:

Funding Method	Self-Funded	Flex-Funded	Fully Insured
Funding Method Description	Claim dollars based on services delivered to members are paid by the Trust, along with plan administrative fees to manage the plan (process claims, provide call center for members, etc.)	Insurance approach where most claim dollars based on services delivered to members are paid by the Trust, but with fixed costs for certain health care services ("capitation") as well as plan admin fees and large claim reinsurance mechanism ("pooling") at $1 million per participant annually	Health plan sets fixed dollar plan premiums to cover expected claim costs for health care services by members, as well as plan administrative fee costs.
Who Calculates the Recommended SFHSS Plan Rates that HSB approves?	Aon actuary using Aon-determined cost trend assumptions and health plan-determined administrative fees (and required legislative fees)	Aon actuary using plan-determined cost trend assumptions that are validated by Aon actuary, and health plan-determined administrative/large claim pooling fees (and required legislative fees)	Plan's actuary using plan-determined cost trend assumptions which are scrutinized by Aon actuary, and health plan-determined admin fees/large claim pooling adjustments (and required legislative fees)
SFHSS Plans by Funding Method	• Non-Medicare PPO • Delta Dental Active Employee PPO	• Blue Shield of CA Access+ HMO • Blue Shield of CA Trio HMO • Health Net CanopyCare HMO	• All Kaiser HMO plans • BSC Medicare Advantage PPO • Delta Dental Retiree PPO • DeltaCare Dental HMO • UHC Dental HMO • VSP Vision
HSB Rate Stabilization Policy Applies?	Yes	Yes	No

Health Plan Cost and Utilization Experience Reviews

Each March and April, the Actuary reviews plan cost and utilization experience for the recently completed prior plan year for each SFHSS health plan with the HSB.

- SFHSS plan experience serves as the basis of information to be utilized by the plans (for flex-funded and fully insured funding) and actuary (for self-funded funding) to develop recommended rates for the following plan year. Report includes areas:
  - Medical, Prescription Drug, and Dental Claims
  - SFHSS-Specific Top Diagnostic Spend Categories
  - Inpatient Admission Categories
  - Outpatient Visit Categories
  - Health Status/Immunization/Preventive Care Rates by Population

Industry Resources

10-County Survey (typically approved in March)

- As outlined in the City Ordinance, prior to the second Monday in January in the year, or such time consistent with the plan year set by the Board, the Board shall ensure a survey is conducted of the 10 largest counties in California, other than the City and County of San Francisco, to determine the average contribution made by each employer of such county to health benefit coverage. Based on the survey, the Board shall determine the average contribution made with respect to each employee by the 10 counties toward the health care plans provided for their members.

Aon Health Value Initiative (HVI) Benchmarking Study (typically reviewed in April)

- The study gathers comparative information on cost of medical care and prescription drugs, comparing SFHSS data to a database of about 800 employer. This study focuses on data on people who are currently working.

Supplemental Information About Health Care Marketplace Trends

- The SFHSS Chief Financial Officer (CFO) and Actuary will often update the HSB at the start of the R&B cycle on current health care cost dynamics, supplemented periodically by Board Education throughout the year on important health care topics (such as Pharmacy as presented in November 2024).

Rate Setting Methodology (detailed presentation follows)

The San Francisco City Charter outlines guiding rules for contributions. Once the final rates are approved by the HSB the total cost of rates are calculated. Rate-setting methodologies apply for each SFHSS member group-active employees and retiree populations.

Active and Non-Medicare Retirees rate calculations include:

- Active employees versus non-Medicare retirees within a plan
- Plan rates vary by which plan a member chooses: fully insured, flex-funded, and self-insured.
- By dependent coverage tier (single/two-party/family) within a plan. Plan rates are allocated into three dependent tiers
  - Employee/Retiree only
  - Employee/Retiree only +1 dependent
  - Employee/Retiree only +2+ dependents

For Actives, each employer group sets a specific employer contribution and employee contribution rate

- City/County of San Francisco (CCSF)
- San Francisco Unified School District (SFUSD)
- City College of San Francisco (CCD)
- Superior Court
- Municipal Executives Association (MEA)

For Retirees, rate calculations are guided by City Charter formulas:

- Employer Contributions For Retirees Are Guided by City Charter Formula
  - Element that is same for all plans: 10-County Amount
  - First element that varies for each plan: “Actuarial difference”
  - Second element that varies for each plan: Retiree Prop. E Contribution
- Rates calculation rules vary depending on those Retirees Hired On or Before January 9, 2009
- Dental Plans are fully contributory for retirees (no employer contributions)

Rates and Benefit Rates and Contributions Proposals

SFHSS will bring the proposed rates and health plan benefit changes to the HSB, and the HSB will approve the following rates and contributions for each type of plan:

1. Life Insurance, Accidental Death & Dismemberment, and LTD Plans
2. Vision Plans
3. Dental Plans
4. Health Plans
   - Health Net CanopyCare HMO
   - Blue Shield of California HMOs (Access+, Trio) and PPOs (Non-Medicare, MAPD)
   - Kaiser Permanente HMOs

HSB Package of R&B After Final Approval

- After final HSB R&B approvals in June, the R&B Benefits package for the following plan year is submitted to the BOS later in June
- SFHSS presents the R&B package for the following plan year to the BOS Budget and Finance Committee, which then recommends the package to the full BOS for their action in July
- Per the City Charter, approval of the following year's R&B package requires approval from at least three-fourths (75%) of BOS members then approval by the Mayor