San Francisco Health Service System
Health Service Board

Non-Medicare Health Plan Rating Methodology

Part 1—Total Cost Rate Setting Process

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Non-Medicare Health Plan Rating Methodology—Introduction

This discussion provides information to the Health Service Board (HSB) of the San Francisco Health Service System (SFHSS), as well as other interested parties, regarding how health plan rates are set for SFHSS health plans for the active employee and early retiree populations (e.g., non-Medicare populations). This presentation document was prepared and delivered via video recording by Mike Clarke of Aon (lead actuary for Aon's engagement with the HSB and SFHSS) in early April 2020.

This discussion has emerged to address periodic questions raised by HSB members, as well as in public comments during HSB meetings, about the relationship of health plan rates across:

- Active employees versus early retirees within a plan;
- By dependent coverage tier (single/two-party/family) within a plan; and
- Across health plans offered by SFHSS.

Today's discussion—how are these rates calculated?

Non-Medicare Health Plan Rating Methodology

"The End State"—2020 Monthly Rates and Contributions

- Five health plans and three dependent coverage tiers
- Two major population segments (active employees and early retirees)
- Multiple employer contribution determination rules within each segment—including by employer for active employees (CCSF* example shown below), percentage of full employer (ER) contribution for retirees (partial for some hired on/after January 10, 2009)

	Active Employees (93/93/83)			Active Employees (100/96/83)			Early Retirees (Full ER Contribution)		
	EE Only	EE+1 Dep	EE+2+ Deps	EE Only	EE+1 Dep	EE+2+ Deps	RET Only	RET+1 Dep	RET+2+ Deps
Total Plan Rates									
o UHC City Plan PPO	$1,185	$2,295	$3,232	$1,185	$2,295	$3,232	$1,511	$2,400	$3,085
o UHC CP-C.N.A.	$892	$1,781	$2,519	$892	$1,781	$2,519	$1,511	$2,400	$3,085
o BSC Access+	$892	$1,781	$2,519	$892	$1,781	$2,519	$2,059	$2,984	$3,722
o BSC Trio	$754	$1,505	$2,128	$754	$1,505	$2,128	$1,739	$2,519	$3,143
o Kaiser CA	$646	$1,288	$1,822	$646	$1,288	$1,822	$1,296	$1,938	$2,472
Employer Contribution									
o UHC City Plan PPO	$829	$1,656	$2,091	$1,185	$1,710	$2,091	$1,271	$1,716	$1,716
o UHC CP-C.N.A.	$829	$1,656	$2,091	$892	$1,710	$2,091	$1,418	$1,862	$1,862
o BSC Access+	$829	$1,656	$2,091	$892	$1,710	$2,091	$1,966	$2,429	$2,429
o BSC Trio	$701	$1,399	$1,766	$754	$1,444	$1,766	$1,715	$2,105	$2,105
o Kaiser CA	$601	$1,198	$1,512	$646	$1,237	$1,512	$1,296	$1,617	$1,617
Member Contribution									
o UHC City Plan PPO	$356	$639	$1,142	$0	$585	$1,142	$240	$684	$1,369
o UHC CP-C.N.A.	$62	$125	$428	$0	$71	$428	$93	$538	$1,223
o BSC Access+	$62	$125	$428	$0	$71	$428	$93	$555	$1,293
o BSC Trio	$53	$105	$362	$0	$60	$362	$24	$414	$1,037
o Kaiser CA	$45	$90	$310	$0	$52	$310	$0	$321	$855

* CCSF = City/County of San Francisco; figures above rounded to nearest dollar for illustrative purposes

Non-Medicare Health Plan Rating Methodology—Agenda

Our discussion is segmented into four primary topic areas:

(1) How Aon (for self-funded/flex-funded plans) and health plans (for fully insured plans) perform rate setting activities for next year's health plan rate recommendations.

(2) How total cost rates are segmented into employer and member contributions for each population segment—(a) active employees and (b) retirees.

(3) Historical perspective on SFHSS health plan rate relationships across health plans and dependent coverage tiers, given historical influence on current methodologies.

(4) Current state of SFHSS health plan rate relationships across health plans and dependent coverage tiers.

We will then close Part 4 with perspectives for the future on whether the HSB and SFHSS may want to pursue changes in current elements of non-Medicare health plan rating methodology.

This presentation segment addresses Part 1—Total Cost Rate Setting Process.

Part 1: Total Cost Rate Setting Process

Self-Funded Plan Total Rates—Calculation Process

- 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 Process

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

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

Historical Claims

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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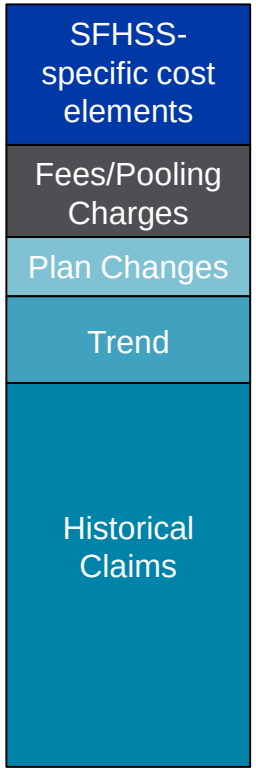
Self-Funded Plan Total Rates—Step #5

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 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 Process

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 Process

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