



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
<b>Total</b>	<b>\$0.02</b>	<b>\$0.15</b>	<b>\$0.11</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.28</b>



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
<b>Total</b>	<b>\$0.02</b>	<b>\$0.11</b>	<b>\$0.09</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.22</b>

### 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)
<b>Current Rates</b>	<b>\$81.3</b>	<b>\$654.0</b>	<b>\$735.3</b>
<b>Final Renewal Rates</b>	<b>\$85.6</b>	<b>\$685.1</b>	<b>\$770.7</b>
\$ 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 the 100/96/83 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 Permanente 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 Health 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.



<b>TABLE 3 *</b>					
<b>Distribution of Aggregate Plan Costs (\$millions)</b>					
	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
<b>Kaiser HMO **</b>	<b>\$39.7</b>	<b>\$335.6</b>	<b>\$375.3</b>	<b>10.58%</b>	<b>89.42%</b>
\$ Increase	\$2.0	\$17.4	\$19.4		
% Increase	5.37%	5.48%	5.46%		
<b>Blue Shield HMO **</b>	<b>\$39.6</b>	<b>\$304.7</b>	<b>\$344.3</b>	<b>11.51%</b>	<b>88.49%</b>
\$ Increase	\$1.2	\$7.5	\$8.7		
% Increase	2.99%	2.53%	2.58%		
<b>City Plan **</b>	<b>\$6.2</b>	<b>\$44.8</b>	<b>\$51.0</b>	<b>12.21%</b>	<b>87.79%</b>
\$ Increase	\$1.1	\$6.2	\$7.3		
% Increase	22.10%	15.93%	16.65%		
<b>Dental ***</b>	<b>\$3.6</b>	<b>\$43.9</b>	<b>\$47.5</b>	<b>7.56%</b>	<b>92.44%</b>
\$ Increase	\$0.0	\$0.4	\$0.4		
% Increase	0.00%	0.83%	0.76%		
<b>LTD</b>	<b>\$0.0</b>	<b>\$6.9</b>	<b>\$6.9</b>	<b>0.00%</b>	<b>100.00%</b>
\$ Increase	\$0.0	\$0.2	\$0.2		
% Increase	0.00%	2.54%	2.54%		
<b>Life</b>	<b>\$2.5</b>	<b>\$0.9</b>	<b>\$3.4</b>	<b>72.67%</b>	<b>27.33%</b>
\$ Increase	\$2.3	\$0.0	\$2.3		
% Increase	1036.36%	4.44%	207.14%		
<b>Total</b>	<b>\$91.6</b>	<b>\$736.8</b>	<b>\$828.5</b>	<b>11.06%</b>	<b>88.94%</b>
\$ 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



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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,

A handwritten signature in black ink that reads "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