SAN FRANCISCO HEALTH SERVICE SYSTEM

Health Service Board

Self-Funded Plans' Stabilization Policy

(formerly known as the Funding Policy)

Policy Objectives

The objective of a stabilization reserve is to spread any underwriting gains or losses into following year's premium calculation in an even-handed manner such that the Employers and membership are not subject to volatile year over year changes in premium.

Policy History

The Board adopted this policy on March 12, 2008, amended it on March 14, 2013, amended it on February 13, 2014 and amended it again on January 8, 2015.

This policy has been applied to City Plan annually since 2007.

Review

The Board shall review this policy at least every three years.

Stabilization Policy

This policy standardizes the methodology that will be used to incorporate the impact of prior year revenue excess and shortfalls against projected expense in future self-funded plans' premium rate requirements. The purpose of a Stabilization Policy is to even out the premium fluctuations year-to-year.

The Health Service System's (HSS) self-funded health plans covered by this policy include:

- The Self-Funded PPO City Plan
- The Flex-Funded/Self-Funded HMO Plan(s)
- The Self-Funded Dental PPO

As described in the Methodology section below, a rolling three-year period will be used to reflect prior year revenue excess and shortfalls against projected expense in the City Plan.

The methods specified in this document will be applied annually during the rate-setting process to plan year premium rates using the revenue excess or shortfall experienced during the prior plan years.

The actuarial consultant firm presents the recommendation and supporting analysis to the HS Board for approval of the stabilization reserve calculation each year during the rate setting process.

Definitions

Contingency Reserve: Any actuarial estimate is based upon the information available at a point in time and is subject to unforeseen and random events. At any point in time, estimated reserves may be higher or lower than required. Future funding projections will generate revenue that may be higher or lower than actual experience.
There are multiple factors that impact the eventual experience of the self-funded health plans. The range of plausible results around the best estimate rates would consider:

- Random variation from expected claims
- Credibility of the experience
- Fluctuations in large claims experience
- Vendor processing stability
- Changes in COBRA enrollment
- Catastrophic events and whether to make allowance or not

The contingency margin is intended to immunize against such adverse experience.

IBNR Reserve: Reserve for estimated claims that have been incurred by members but not yet processed, including unknown future developments on existing claims.

Methodology

The self-funded plans' premium rates for plan year X will consist of the following five components:

- Estimated incurred claims cost for plan year X
- Estimated cost of administering the claims over plan year X
- Estimated cost of any fully insured products (i.e. EGWP premium) over plan year X
- Estimated change in the ***Contingency Reserve*** over plan year X
- Factor reflecting revenue excess or shortfall experience from prior plan years

The first three components of the self-funded plans' premium rates (incurred claims, administrative costs, and, if applicable, any fully insured premium) are common to the in-force premium rates. Unlike the change in ***IBNR*** *(Incurred but not reported),* which is implicitly included in the projection of incurred claims, the Contingency Reserve is added as a component of each plan's targeted year-end funding level. The anticipated change in the Contingency Reserve is factored into the rate requirements as the fourth component of the self-funded plans' premium rates.

The fifth component of self-funded plans' premium rates "Factor reflecting revenue excess or shortfall experience from prior plan years", is the focus of this policy.

The methodology used to determine the "Factor reflecting revenue excess or shortfall experience from prior plan years" varies by plan.

The revenue excess or shortfall in any plan year will be determined by comparing the following two amounts:

1) Expected Revenue = Expected incurred claims + Expected administration costs + Expected fully insured premium (if applicable) + Expected change in Contingency Reserve

   The expected revenue amount will be based on the per capita estimates for the plan year aggregated using actual plan year enrollment.

2) Actual Revenue = Actual incurred claims + Actual administration costs + Actual fully insured premium (if applicable) + Actual change in Contingency Reserve

The methodology described should be reviewed at a minimum every three years to confirm its continued appropriateness.

Example: The City Plan (UHC)

For plan year X, this component equates to one third of the cumulative difference between prior years' revenue and expense less prior years' release of this amount.

An illustration is provided below:

Revenue excess in year X-2 = $90
Premium rates for plan year X includes an offset of $30, i.e. one-third of $90, thus leaving a balance of $60

Revenue excess in year X-1 = $90
Premium rates for plan year X+1 includes an offset of $50, i.e. one-third of the accumulation of $150 (($90 - $30) + $90 = $150), thus leaving a balance of $100

Revenue shortfall in year X = -$70
Premium rates for plan year X+2 includes an offset of $10, i.e. one-third of the accumulation of $30 (($90 - $30) + ($90 - $50) - $70 = $30), thus leaving a balance of $20

Allocation of cumulative revenue excess or shortfall across categories of membership

To develop the premium rate factor, allocation of the cumulative revenue excess or shortfall across categories of membership (employees/non-Medicare retirees/Medicare retirees) is proportional and is based on the aggregate of the projected claims costs, administration costs, fully insured premium costs (if applicable), and Contingency Reserve increase/decrease over the plan year in question.

An illustration is provided below:
The projected claims costs, administration costs, fully insured premium costs (if applicable), and Contingency Reserve increase/decrease over the plan year for the City Plan in year X are expected to be $60 million and this is split across membership categories as follows:

Employees: $20 million
Non-Medicare Retirees: $10 million

Medicare Retirees: $30 million

There is also a cumulative revenue excess amount of $6 million to be allocated across membership categories, the allocation in the calculation of premiums for plan year X would be as follows:

Employees: $2 million
Non-Medicare Retirees: $1 million
Medicare Retirees: $3 million