# San Francisco Health Service System
# Health Service Board

## Health Plan Market Assessment Discussion

July 11, 2019

**Prepared by:**
Health Solutions

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# Today's Discussion Agenda

- **Industry activities—nationally, locally, and impact**
- **Defining the major players and opportunities in today's health care ecosystem**
- **Spectrum of health benefit design and contracting strategies**
- **Factors driving health plan market assessments today—evolution, SFHSS strategic goals, ideal state framework and considerations, other factors for consideration**
- **Health system models—current and possible alternative scenarios for SFHSS**
- **Recap of today's discussion and next steps**
- **Appendix—glossary of acronyms**

# Goals of Today's Discussion

- **Today's discussion focus is on SFHSS health plans available to active employees and early retirees (e.g., non-Medicare populations)**
  - Striving to inform and gather input for the planned RFP to be released in early 2020 for a January 1, 2022 effective date

- **Discuss and identify "must haves" for current and future carrier partners:**
  - Full acceptance and immersion of SFHSS strategic goals into all aspects of operations from administrative to clinical
  - Deep understanding of the health and unique, and varied health care needs of the SFHSS population
  - Ability to ensure quality and high value care
  - Modernization and inclusivity of digital solutions while enhancing high touch care when members seek care
  - Emphasis on interoperability and integration of consumer data amongst partners and ultimately with the member

# Goals of Today's Discussion

- **Throughout todays discussion and future discussions, gather input on how to further define carrier partner success metrics**

- **SFHSS is looking for carrier partners who:**
  - Have a well articulated population health strategy including:
    - How the carrier defines and stratifies the population based on clinical severity
    - How the carrier achieves true member engagement in their health outcomes
    - Well defined and measured in-house and partner programs
    - A variety of engagement tools: telephone, virtual, apps, etc.
    - Plans and programs that address the full continuum of health needs (whole-person physical, emotional, and social needs)
    - Outcomes-based metrics that focus on member health improvement
  - Will partner with SFHSS on innovative programs to support SFHSS' strategic goals

# Industry and Market Review

- **Industry activities—nationally, locally, and impact**
- **Defining the major players and opportunities in today's health care ecosystem**
- **Spectrum of health benefit design and contracting strategies**
- **Factors driving health plan market assessments today—evolution, SFHSS strategic goals, ideal state framework and considerations, other factors for consideration**

# Health Industry Vertical Integration is Creating Opportunity


## Comments

- Each of the major health plans has vertically integrated with a Pharmacy Benefit Manager (PBM)
- Due to the large volume of existing cross-vendor business, carriers are expected to continue to work together and with Third-Party Administrators (TPAs) or other PBMs
- Kaiser Permanente offers a fully integrated system which includes ownership and management of their own PBM

## Other Noteworthy Deals

Walmart + Humana

amazon.com + Pill Pack

# San Francisco—Health Systems and Carriers

**Largest Hospitals by Bed Capacity / Occupancy [1]**

1) UCSF Medical Center: 726 / 85%
2) San Mateo Medical Center: 509 / 70%
3) Stanford Health Care: 474 / 89%
4) CPMC Pacific Campus: 436 / 87%
5) Highland Hospital: 372 / 80%
6) Stanford Children's Health: 324 / 72%

**Largest Physician Organizations by Provider Count [2]**

1) UCSF Medical Group: 1,879
2) Brown & Toland: 1,276
3) Hill Physicians — San Francisco: 991
4) Permanente Medical Group: 398
5) Chinese Community Health Care Associates: 207

**Largest Carriers [3]**

1) Kaiser Foundation Group: 60%
2) Blue Shield of CA: 21%
3) UnitedHealth Group: 6%
4) Aetna: 2%
5) Anthem: 2%
6) Cigna: 2%
7) Centene: 1%

***Notes:***

***[1]*** **Largest Bay Area Hospitals Ranked by Average Number of Staffed Days, San Francisco Business Times (accessed July 9, 2019)**

***[2]*** ***California Health Care Foundation: Empire Building by the Bay: Consolidating Control of Hospitals and Physician Organizations in the Bay Area (2016)***

***[3]*** ***Aon's proprietary database for San Francisco as of May 17, 2019***

# Consolidation and Merger / Acquisition (M&A) Impacts

## Hospitals

- Employing more physicians
- Expanding via M&A
- Leverage over insurers growing as carrier mergers were blocked
- Larger market presence protects from price concessions and being excluded from narrow networks
- Facing new requirements around transparency and chargemaster (a listing of facility charges before any insurance discounts) reporting

## Physicians

- Physicians continue flocking to groups
- Not ready for the coming shift to value (staffing / technology)
- Primary Care Provider (PCP) shortage will drive change — most likely more virtual care and increased utilization of physician assistant and nurse practitioner roles
- High rates of burnout across all specialties

## Insurers

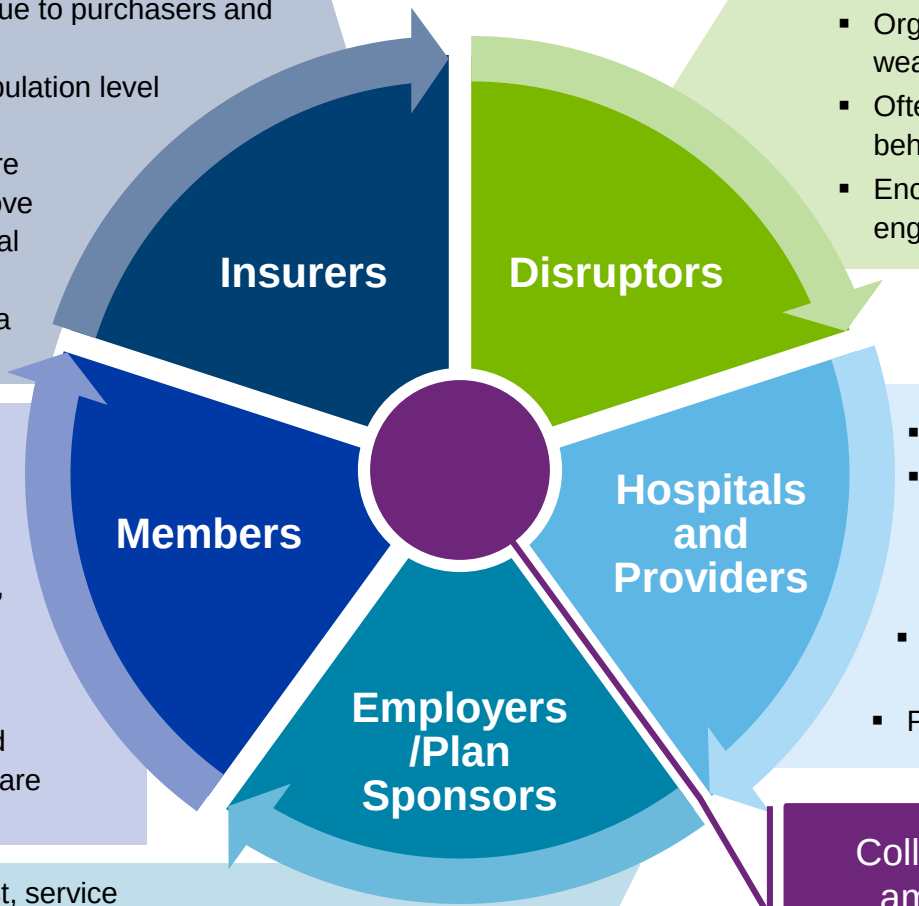
- Merger attempts failed
- Vertical integration is happening (PBMs and provider groups)
- Narrow networks not popular with employers and plan sponsors
- Under attack from myriad of startups across many product lines

Overall, based on Herfindahl-Hirschman Index (HHI), market concentration has accelerated in all three categories above during the last decade (details in appendix).

# Major Players in the Opportunities in the Health Care Ecosystem

- Challenged to deliver better value to purchasers and members
- Must transform to balanced population level risk with consumer need
- Enhanced engagement and care coordination strategies to improve health with high touch and digital devices
- Focus on interoperability of data owned by consumer

- Organizations built to fix gaps and weaknesses in the system
- Often using technology to drive behavior change
- Encourage and support member engagement in health care journey




- Represent a diverse range of socioeconomic features
- Have a varied range of health care needs
- Want personal caring, effective, affordable care
- Often know they need better health behaviors
- Seeking support, guidance, and continuity across the range of care connection points

- Consolidating
- Seeking clinical integration, accepting more risk, and resistant to change (starting to become open to conversations)
- PCPs influence care and most of cost
- Pulled by many competing forces

- Wrestling with disparities in cost, service quality, and uniformity of quality indicator reporting
- Recognize that plan design and cost shifting to employees is not the answer
- Deciding how to help employees make the right choices
- Challenged by an unhealthy and aging workforce

Collaboration and integration amongst these parties will become critical to changing health care delivery



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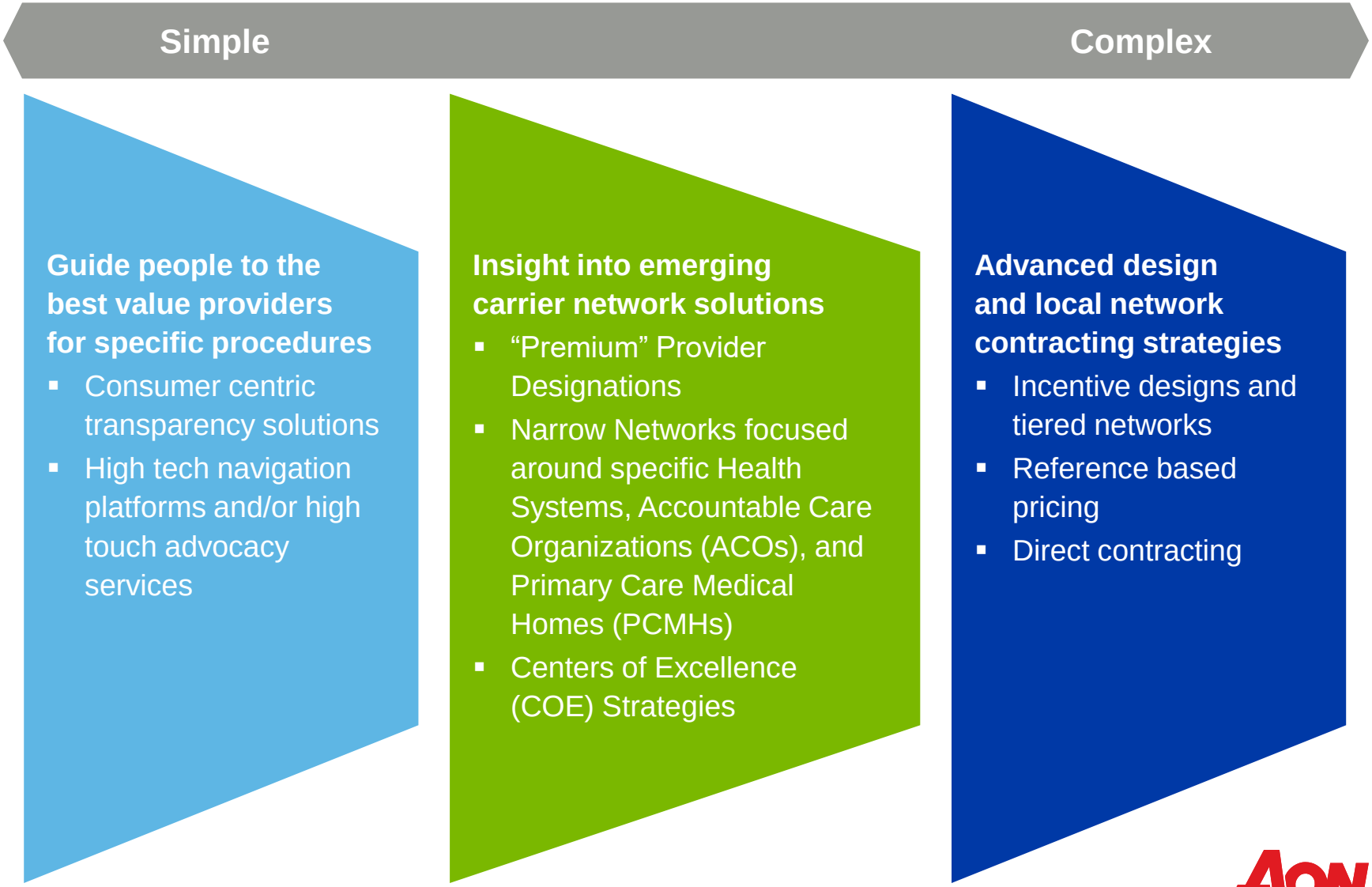
# Spectrum of Health Benefit Design and Contracting Strategies



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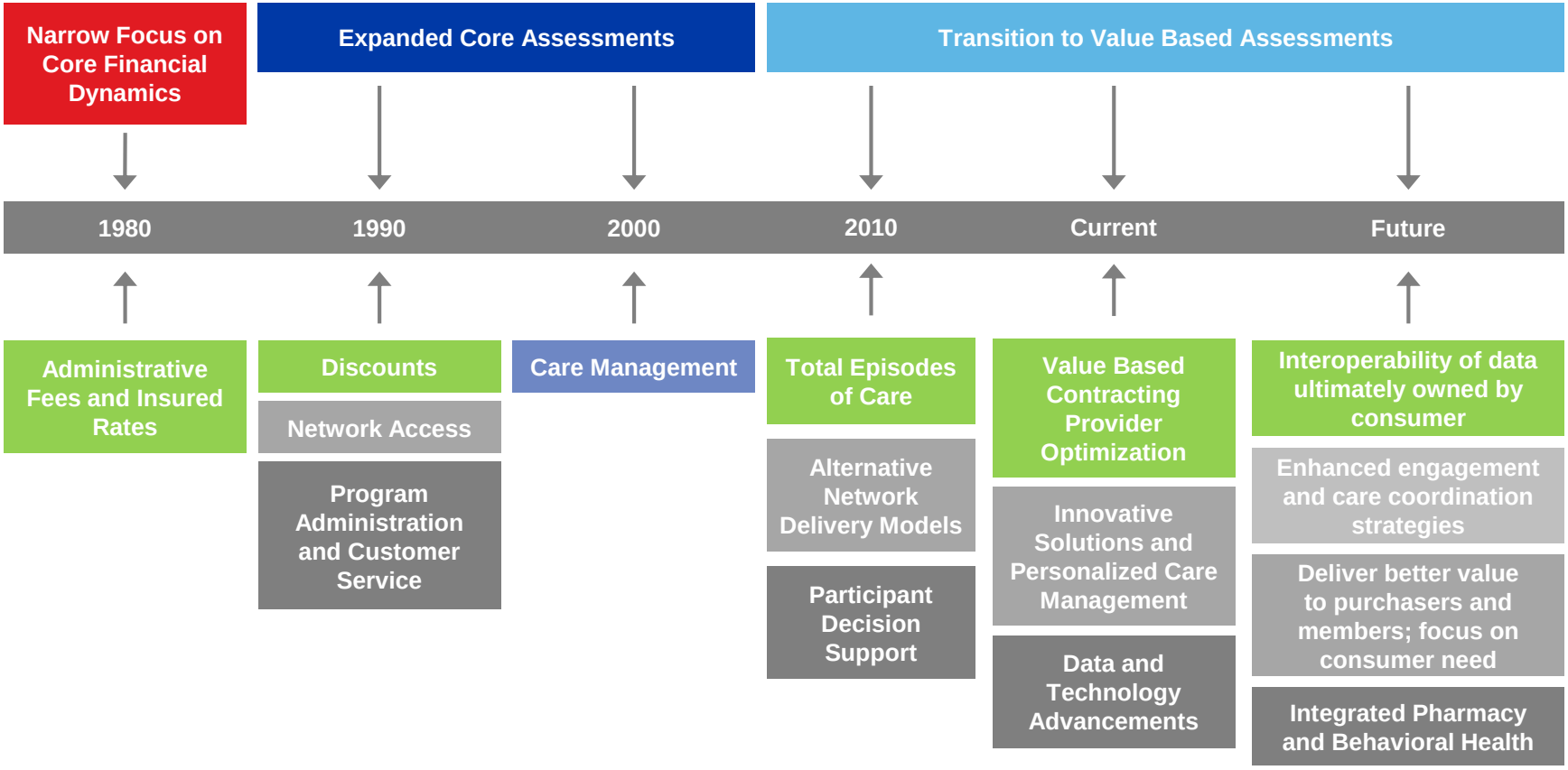
# Evolving Factors Driving Health Plan Market Assessments

**Historically, market assessments were driven by a desire to lower administrative fees, maximize discounts, and address service issues.**
**In today's environment, change catalysts have evolved significantly.**



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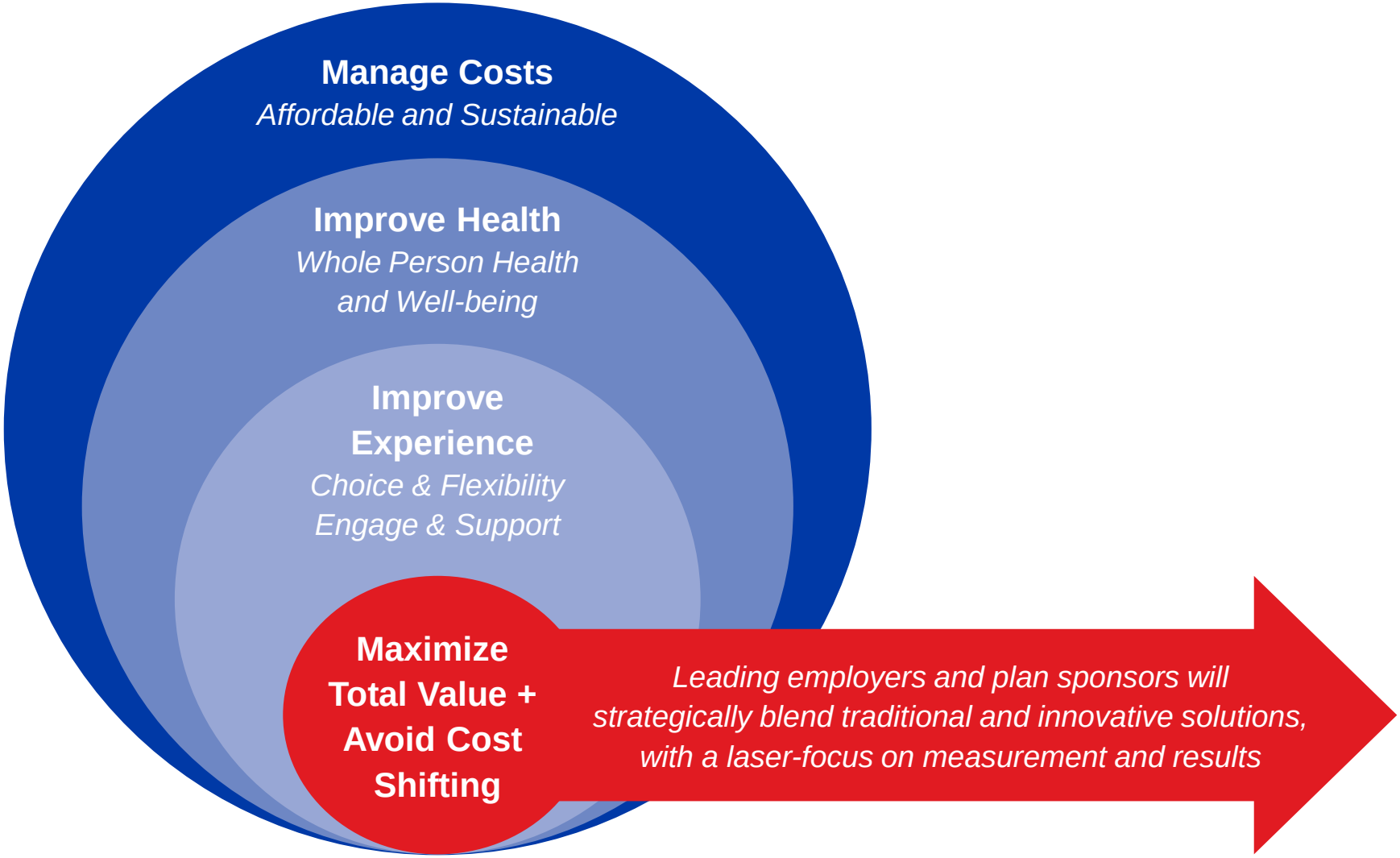
# The New Bottom Line

## New Challenges, New Targets, New Solutions



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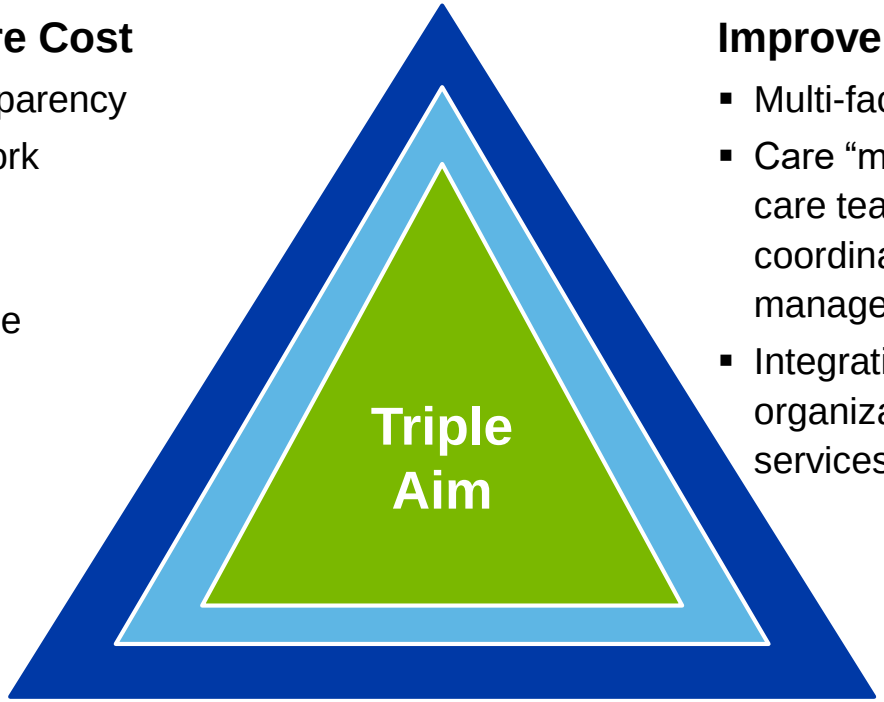
# SFHSS Strategic Plan Goals

- **Affordable and Sustainable:** We aspire to transform health care purchasing and care delivery to provide quality, affordable and sustainable health care for our current and future members through value driven decisions, programs, designs, and services.
- **Reduce Complexity and Fragmentation:** We believe in moving toward an integrated delivery system, focusing on primary care and prevention through targeted personalized care.
- **Engage and Support:** We aim to activate programs, services, and resources that address the entire cycle of health, elevating engagement, and strengthening member knowledge and confidence in accessing and using health and benefit plans.
- **Choice and Flexibility:** We believe in offering a spectrum of designs, costs and services and collaborating with our stakeholder organizations, agencies, and departments to deliver on the whole person perspective.
- **Whole Person Health and Well-being:** We believe an organization that values and holistically supports members and their families' lives and that fosters an environment and culture of well-being will have a happier, healthier, and more engaged population.

# Ideal State

## Minimize Health Care Cost

- Cost and quality transparency
- High performing network
- Value-based provider contracts
- Financially accountable vendor relationships




## Improve Population Health

- Multi-factorial risk stratification
- Care “matching” to complex care team, care manager / coordinator, practice-based management, or self-care
- Integration of community-based organizations and social services

## Optimize Member Experience

- Convenient, coordinated and tailored care
- Health plan and provider interoperability
- Varied site of care—provider office, tele-health, virtual, in-home, remote monitoring
- Care coordination / advocacy / navigation



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# Considerations to Identify the Ideal State of Partnership

- **Will relationships continue to exist at the health plan level as it does today? Or will it be direct with health systems?**
  - Health plan examples: Blue Shield of California, UnitedHealthcare
  - Health system examples: Canopy, Aetna/Sutter, Dignity/Anthem, and merger into CommonSpirit (aka Dignity Health)
  - Integrated plan/system examples: Kaiser, CCHP, Sutter
- **What are the parameters to drive change?**
  - Network focus on person-centric, culturally competent care delivery systems
  - Provider / facility contracts (e.g., value-based/pay-for-performance)
  - Data integration / interoperability amongst contracted provider community as well as between traditional care delivery classifications, e.g., “traditional” medical care, pharmaceuticals, behavioral health, wellness, oral and vision care
  - Network steerage to quality, integrated health providers
  - Design steerage to advanced primary care practices
  - Integrated care management and coordination for those acutely and/or chronically ill
  - Range of care connection points: in-person, virtual, tele-health
  - Incorporation of resources and support staff to address social determinants of health

# Health System Models

## Considerations

# Health Plan Models—Spectrum


**Open System**

- UHC PPO
- Discounted fee for service
- Limited care coordination and management
- Individual driven

**ACO / PCMH**

- BSC Trio and Access+
- Capitation + discounted fee for service
- Care coordination and management driven by designated ACO driven

**Staff / Group Model**

- Kaiser
- “Capitation”
- Care coordination and management driven by primary care provider and system

**Organized Systems of Care**




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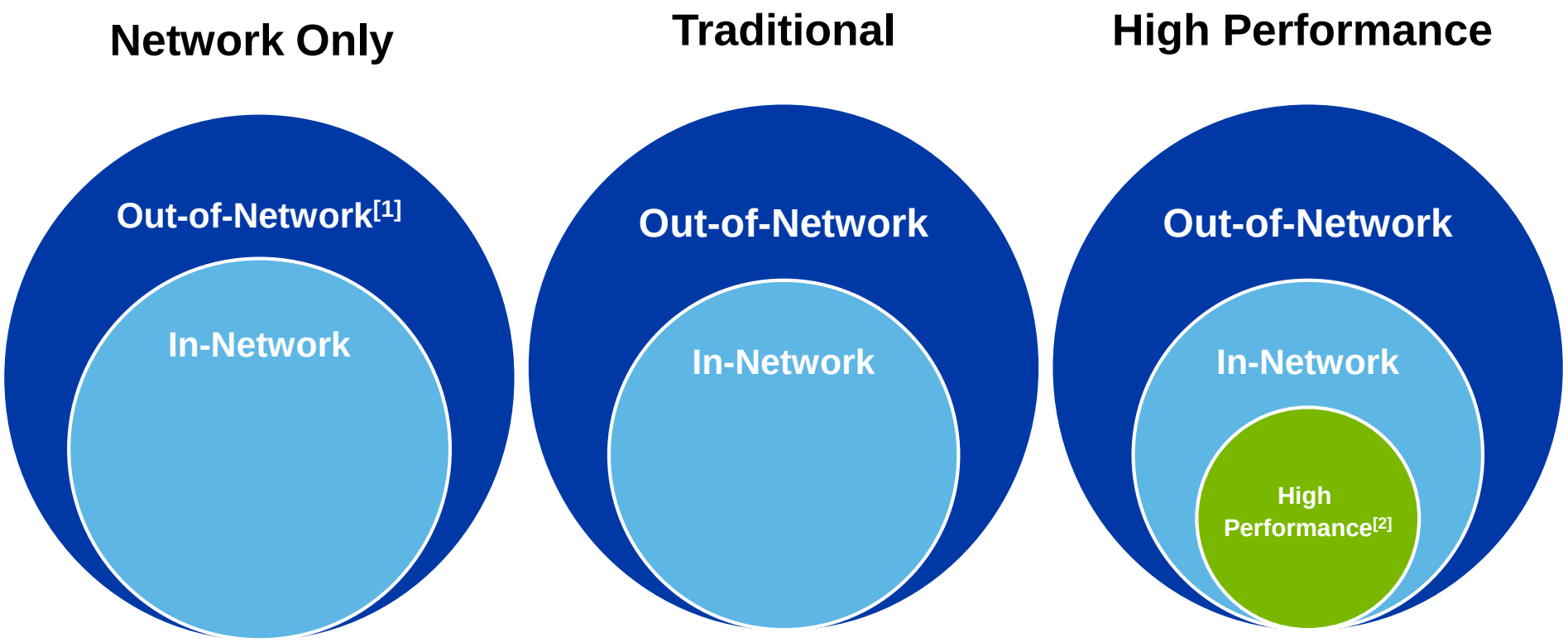
# Network Models




*[1] Out-of-network emergency care only*
*[2] Includes Advanced Primary Care Practices, Clinically Integrated Health Systems, Centers of Excellence / Expertise, Bundled Payment, and/or Value-Based Contracts*



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# Other Components

| Model Elements | Brief Description | Examples |
|---|---|---|
| **Vendor / Carrier / Insurer** | Entity that manages the provider network, processes claims, and provides varying levels of clinical oversight | ▪ Blue Shield of California (BSC)<br>▪ Kaiser Permanente (Kaiser)<br>▪ UnitedHealthcare (UHC) |
| **Funding** | Identifies which entity is taking the risk of claims payments | ▪ Self-funded (UHC)<br>▪ Flex-funded (BSC)<br>▪ Fully insured (Kaiser) |
| **Member Point of Service Cost** | The amount a member pays when seeking care from a provider or hospital | ▪ Copay ($5)<br>▪ Coinsurance (10%)<br>▪ Deductible ($250) |
| **Network** | Identifies providers and hospitals that have or have not contracted with the vendor/carrier/insurer | ▪ In-network (those that have contracted)<br>▪ Out-of-network (those that have not contracted) |
| **Delivery system** | Describes the way in which the providers / facilities are or are not integrated through contracts, data-sharing, shared services | ▪ Staff / Group model (Kaiser)<br>▪ Accountable Care Organization (BSC)<br>▪ Preferred Provider Organization (UHC) |
| **Care Coordination** | The entity / person that assists members in coordinating care across various providers / facilities | ▪ Primary care coordination<br>▪ Acute care coordination<br>▪ Post-acute / long-term care coordination |

# Carve-In vs. Carve-Out Vendors

- Many programs can be carved-in (with the insurer/administrator) or carved-out (with a third-party point solution)
- These can include behavioral health, pharmacy, advocacy, etc.

## CARVE-IN

- Single point-of-contact for contract and vendor relationship management
- Single point-of-contact for member communications, customer services, and claims
- Single-source for data integration
- Leverage episode bundling for managed pricing

## CARVE-OUT

- Flexibility to select vendor of employer/plan sponsor's choosing
- Greater ability to customize the program
- Capitalizing on specialty capabilities to drive better outcomes through vendor with singular focus and expertise

# Additional RFP Considerations

## Core Components of the RFP

- Administrative and program fees
- Provider network access and disruption for members including non-Bay Area members
- Program administration and customer service
- Data and reporting

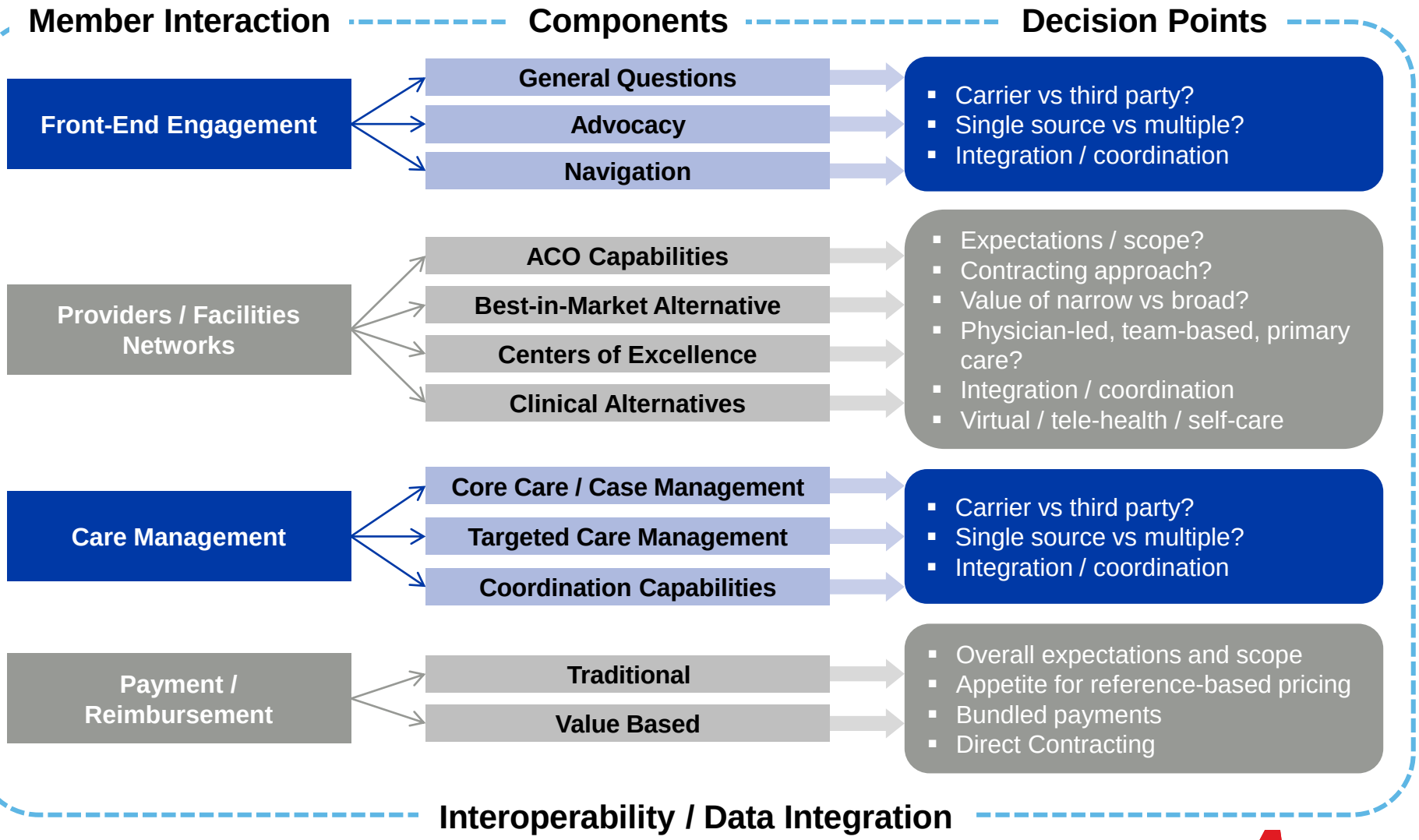
## Additional Areas of Review

- Technology and innovation
- Demonstrable ability to shape outcomes
- Willingness to guarantee success
- Service level agreements = “price of admission”
- Performance guarantees = targeted and substantive commitments

## Funding Discussion

- Current—blend of fully insured, flex-funded, and self-funded
- Consider impacts of transition to alternative funding methods for one or more plans based upon recommendations coming out of RFP analysis

# Using Member "Touch Points" To Shape RFP



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# Health System Models

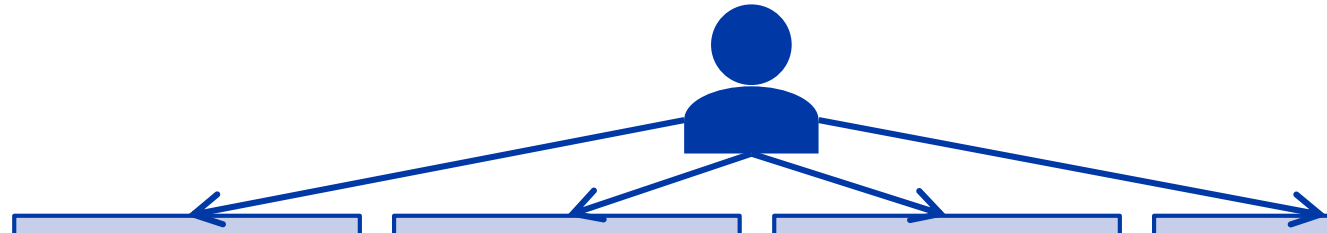
## Current and Possible Alternative Scenarios for SFHSS

# 5 Models for Discussion

- The following slides will walk through a sampling of possible models to gather feedback

| Model | Focus | Description |
|---|---|---|
| **Current State** | Status quo | ▪ Three carriers: Kaiser, Blue Shield, UnitedHealthcare<br>▪ Four plans: Three HMO and one PPO |
| **Current State: Enhanced** | Status quo with enhanced advocacy / navigation | ▪ SFHSS current model with three carriers and four health plans (three HMO and one PPO)<br>▪ Enhanced care advocacy / navigation for non-Kaiser plans |
| **Consolidated** | Retain plan choice while consolidating carriers to two | ▪ Two carriers: Kaiser plus one other<br>▪ Three plans: Two HMO and one PPO |
| **System Competition** | Retain plan choice with member choice at the health system level | ▪ Two+ carriers: Kaiser plus other integrated health carriers<br>▪ Two+ plans: A variety of HMO and/or PPO options |
| **Private Exchange** | Broad carrier and plan choice for members | ▪ Create SFHSS-specific private exchange platform that offers all major carriers and a variety of plans under each |

# Health Plan Models—Current State



| | Kaiser | BSC Access+ | BSC Trio | UHC PPO |
|---|---|---|---|---|
| What are my choices at annual enrollment? | **Kaiser** | **BSC Access+** | **BSC Trio** | **UHC PPO** |
| Where can I seek care? * | Kaiser | Contracted in-network providers and hospitals only | Contracted in-network providers and hospitals only | Any provider or hospital (in- and out-of-network coverage available) |
| Do I need a referral from my PCP to get care? | Yes | Yes — PCP selected from BTMG or Hill Physicians | Yes — PCP selected from BTMG or Hill Physicians | No |
| How much do I pay? | Generally a copay, e.g., $20 for an office visit | Generally a copay, e.g., $25 for an office visit | Generally a copay, e.g., $25 for an office visit | Generally a deductible plus coinsurance, e.g., $250+15% for an in-network office visit |
| Who coordinates my care? | Your Kaiser Primary Care Provider and Kaiser Health Plan | Your Primary Care Provider you identified through your selected ACO | Your Primary Care Provider you identified through your selected ACO | You |

**** General information, does not address emergency care which can be sought anywhere***



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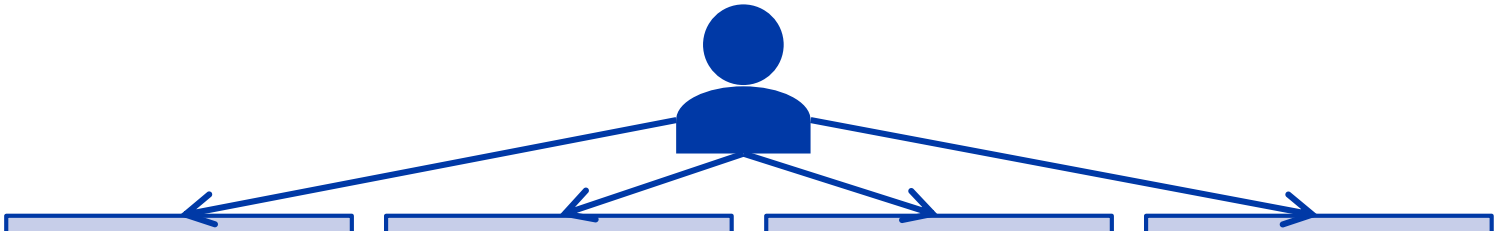
# SFHSS RFP Consideration—Current Scenario

**Considerations to Maintain Existing Health Plan Vendor Structure (Three Carriers)**

- No member disruption in plan offerings to members—especially if Kaiser, BSC, and UHC are all retained as an RFP outcome
- However, UHC PPO long-term sustainability concerns will continue given relative small size of that group in SFHSS health plan ecosystem (3% of non-Medicare members) and much higher-than-average health risk among UHC PPO enrolled population
- Having three separate carriers managing claims limits ability to negotiate with UHC and spread the risk across the non-Kaiser plans

# Health Plan Models—Enhanced Current State



| What are my choices at annual enrollment? | Kaiser | BSC Access+ | BSC Trio | UHC PPO |
|---|---|---|---|---|
| Where can I seek care? * | Kaiser | Contracted in-network providers and hospitals only | Contracted in-network providers and hospitals only | Any provider or hospital (in- and out-of-network coverage available) |
| Do I need a referral from my PCP to get care? | Yes | Yes — PCP selected from BTMG or Hill Physicians | Yes — PCP selected from BTMG or Hill Physicians | No |
| How much do I pay? | Generally a copay, e.g., $20 for an office visit | Generally a copay, e.g., $25 for an office visit | Generally a copay, e.g., $25 for an office visit | Generally a deductible plus coinsurance, e.g., $250+15% for an in-network office visit |
| Who coordinates my care? | Your Kaiser Primary Care Provider and Kaiser Health Plan | Your Primary Care Provider you identified through your selected ACO | Your Primary Care Provider you identified through your selected ACO | You |
| | | Third-Party Support Services (advocacy / navigation) | | |

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# Health Plan Models—Enhanced Current State

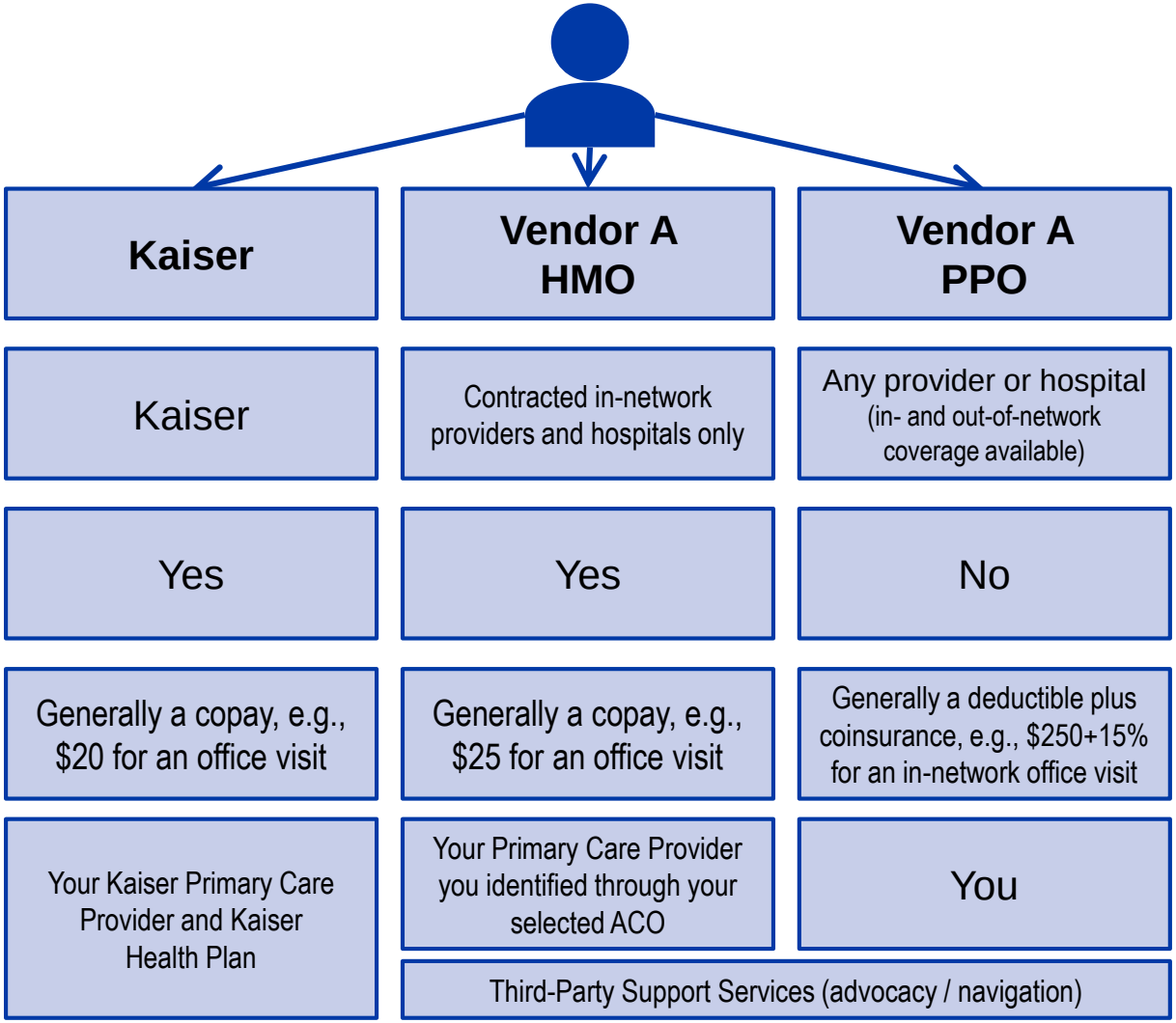
- This model retains the current structure of plan designs (Kaiser, 2 HMOs and 1 PPO)
- Creates enhanced member advocacy/navigation and care coordination through a third party vendor for non-Kaiser plans

# SFHSS RFP Consideration—Enhanced Current Scenario

**Considerations to Maintain Existing Health Plan Vendor Structure (Three Carriers) plus third-party care coordination, navigation, and advocacy**

- No member disruption in plan offerings to members—especially if Kaiser, BSC, and UHC are all retained as an RFP outcome
- However, UHC PPO long-term sustainability concerns will continue given relative small size of that group in SFHSS health plan ecosystem (3% of non-Medicare members) and much higher-than-average health risk among UHC PPO enrolled population
- Having three separate carriers managing claims limits ability to negotiate with UHC and spread the risk across the non-Kaiser plans
- Consider data interface of third-party vendor(s) for advocacy/navigation with what the health plan or ACO provides

# Health System Models—Consolidated Scenario (3 → 2)

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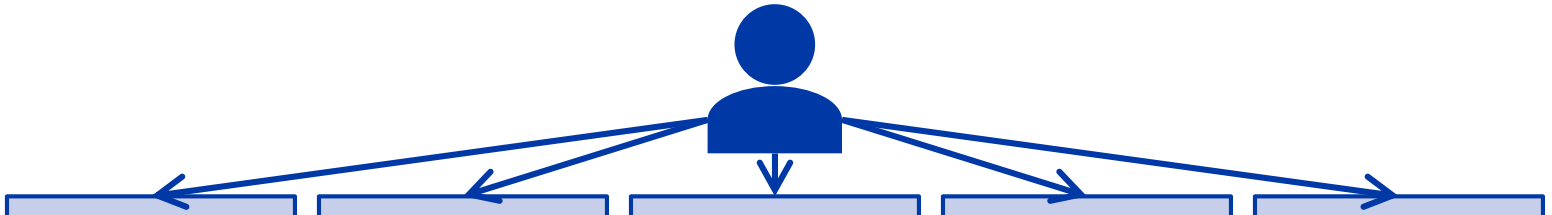
# SFHSS RFP Consideration—Consolidated Scenario

**Considerations to Consolidate to Two Health Plan Vendors**

- There will be some level of member disruption for plans where the RFP results in a carrier change
- Vendor consolidation creates single risk pool for non-Kaiser plan options, which enables plan experience for rate development to be spread across a larger group
  - This could potentially reduce calculated rates for the PPO option, relative to the existing rate development methodology
- Consolidation enables improved fees and contract provision negotiation options for the PPO plan option, as part of a larger population
- Carrier programs and care coordination can be consistently delivered to SFHSS' non-Kaiser members

# Health System Models—System Competition Scenario



| What are my choices at annual enrollment? | Kaiser | ACO 1* | ACO 2* | ACO 3* | PPO |
|---|---|---|---|---|---|
| Where can I seek care? ** | Kaiser | Contracted in-network providers and hospitals only | Contracted in-network providers and hospitals only | Contracted in-network providers and hospitals only | Any provider or hospital (in- and out-of-network coverage available) |
| Do I need a referral from my PCP to get care? | Yes | Yes — PCP selected from ACO 1 | Yes — PCP selected from ACO 2 | Yes — PCP selected from ACO 3 | No |
| How much do I pay? | Generally a copay, e.g., $20 for an office visit | Generally a copay, e.g., $25 for an office visit | Generally a copay, e.g., $25 for an office visit | Generally a copay, e.g., $25 for an office visit | Generally a deductible plus coinsurance, e.g., $250+15% for an in-network office visit |
| Who coordinates my care? | Your Kaiser Primary Care Provider and Kaiser Health Plan | Your Primary Care Provider you identified through your selected ACO | Your Primary Care Provider you identified through your selected ACO | Your Primary Care Provider you identified through your selected ACO | You |

* ***ACO options could include, but is not limited to: Blue Shield, Canopy, CCHP, and/or Sutter***

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# SFHSS RFP Consideration—System Competition Scenario

**Considerations to Expand System Choices for Member Plan Selection**

- It creates competition among health delivery systems to engage and manage members – funding (self-funded, fully insured, etc.) must be carefully crafted to ensure competition is created and balanced for long-term sustainability of each option
- Provider network choice is in the hands of the member at annual enrollment
- Even with expanded plan choices, member disruption is a possibility depending on RFP outcomes
- Immaturity in this market may prevent this from being a viable option for 2022
- Warrants further research into current studies in which early indicators shows increased cost under this scenario

# Health System Models—Private Exchange Scenario

| | Kaiser | Aetna | Blue Plan | Cigna | United Healthcare |
|---|---|---|---|---|---|
| What are my choices at annual enrollment? | | | | | |
| Where can I seek care? * | Kaiser | Any provider or hospital (in- and out-of-network coverage available) | Any provider or hospital (in- and out-of-network coverage available) | Any provider or hospital (in- and out-of-network coverage available) | Any provider or hospital (in- and out-of-network coverage available) |
| Do I need a referral from my PCP to get care? | Yes | No | No | No | No |
| How much do I pay? | Generally a copay, e.g., $20 for an office visit | Varies by Metallic Plan | Varies by Metallic Plan | Varies by Metallic Plan | Varies by Metallic Plan |
| Who coordinates my care? | Your Kaiser Primary Care Provider and Kaiser Health Plan | You | You | You | You |
| | | Third-Party Support Services (advocacy / navigation) | | | |

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# Health System Models—Private Exchange Scenario

- What is a private exchange?
  - Uses a third-party administrative platform to create an exchange-like shopping experience
  - Provides members with a broad selection of “metallic-based” plan options that are standardized across each carrier offered
  - Provides member with a broad selection of carriers
  - The negotiated employee contribution structure would still apply

- A private exchange is **NOT**:
  - **A public exchange**: while it mimics a public exchange there is no relationship between a private and public exchange
  - **Eliminating employer-sponsored benefits:** this model does not send employees to purchase a health plan from a public exchange
  - **A purchasing pool with other employers:** the private exchange is provided only to SFHSS members with premiums that are based only on SFHSS cost and utilization

# SFHSS RFP Consideration—Private Exchange Scenario

**Considerations to Expand Health Plan Choices for Members**

- It creates a full suite of health plan options with standardized plan designs
- Even with expanded plan choices, member disruption is a likely outcome
- Creates more complex member communication and education
- Consider data interface of third-party vendor(s) to for advocacy / navigation with what the health plan
- Limited plan sponsor control on plan design provisions (e.g., deductible, copay, etc.)
- Reduces operations support needed at SFHSS
- Care coordination generally lies with the member and their provider or via a third-party care coordination/navigation vendor
- Likely not a viable option for 2022 but warrants further exploration for the future, possibly in partnership with other public employers in the Bay Area

# Recap of Today's Discussion and Next Steps

# Recap of Today's Discussion

- **Today's discussion focused on SFHSS health plans available to active employees and early retirees (e.g., non-Medicare populations)**
  - The purpose of which was to inform and gather input for the planned RFP to be released in early 2020 for a January 1, 2022 effective date

- **Discussed and identified "must haves" for current and future carrier partners:**
  - Full acceptance and immersion of SFHSS strategic goals into all aspects of operations from administrative to clinical
  - Deep understanding of the health and unique, and varied health care needs of the SFHSS population
  - Ability to ensure quality and high value care
  - Modernization and inclusivity of digital solutions while enhancing high touch care when members seek care
  - Emphasis on interoperability and integration of consumer data amongst partners and ultimately with the member

# Recap of Today's Discussion

- **Discussed how to define and continue to refine carrier partner success metrics**
- SFHSS is looking for carrier partners who:
  - Have a well articulated population health strategy including:
    - How the carrier defines and stratifies the population based on clinical severity
    - How the carrier achieves true member engagement in their health outcomes
    - Well defined and measured in-house and partner programs
    - A variety of engagement tools: telephone, virtual, apps, etc.
    - Plans and programs that address the full continuum of health needs (whole-person physical, emotional, and social needs)
    - Outcomes-based metrics that focus on member health improvement
  - Will partner with SFHSS on innovative programs to support SFHSS' strategic goals

# Next Steps

- Respond to any follow-up questions from today
- Bring back deeper dive into preferred models
- Continue to gather input through community engagement process:
  - Following the July 11, 2019 Special Meeting, multiple member input sessions will be held. SFHSS staff will invite members and other stakeholders to sessions for further dialog and input.
  - The dates, locations of these sessions will be announced by the end of the month.
  - Continue to gather input through member engagement process
  - Please let SFHSS know if you wish to be included/noticed or have questions. Also note that these discussions are regarding the health plans for active and early retirees (pre-Medicare).

# Appendix

# Appendix—Glossary of Acronyms

- **ACO**—Accountable Care Organization: collaboration among physician groups and health systems to deliver integrated care to members
- **BSC**—Blue Shield of California: existing plan carrier for SFHSS Access+ and Trio plans
- **CCHP**—Chinese Community Health Plan
- **COE**—Center of Excellence: health care facility designated as preferred site for delivery of a specialized service (example: organ transplants)
- **HHI**—Herfindahl-Hirschman Index: measures market concentration
- **HMO**—Health Maintenance Organization: health plan offering services only through network providers (except in case of emergency care needs)
- **Kaiser**—Kaiser Permanente
- **M&A**—Mergers and Acquisitions: common in today's health care ecosystem
- **PBM**—Pharmacy Benefit Manager: entity managing the prescription drug component of a health plan

# Appendix—Glossary of Acronyms (continued)

- **PCMH**—Patient-Centered Medical Home: care coordination into health care ecosystem for member is driven by primary care physician
- **PCP**—Primary Care Physician: "quarterback" for a member's health care needs
- **PPO**—Preferred Provider Organization: health plan offering services both through contracted network providers, as well as any other provider via a lesser out-of-network benefit structure
- **RFP**—Request for Proposal: SFHSS' planned request for proposal process to select health plan(s) to offer to SFHSS active employees and early retirees for January 1, 2022 effective date
- **TPA**—Third Party Administrator: entity who administers health plan coverage utilizing provider networks developed by separate entity
- **UHC**—UnitedHealthcare: existing plan carrier for SFHSS City Plan
- **UHC PPO**—Also known as City Plan currently

# Herfindahl-Hirschman Index (HHI)

- The HHI is used by measure insurer, hospital, and physician market concentration. HHI is used in the U.S. Department of Justice and Federal Trade Commission's Horizontal Merger Guidelines (U.S. Department of Justice and the Federal Trade Commission 2010).
- The Horizontal Merger Guidelines consider markets with HHIs between 1,500 and 2,500 points to be moderately concentrated and markets with HHIs in excess of 2,500 points to be highly concentrated. In the context of mergers, the Guidelines assign the highest concern and scrutiny to mergers that would increase the HHI in a market by over 200 points and leave the market with an HHI of over 2,500.

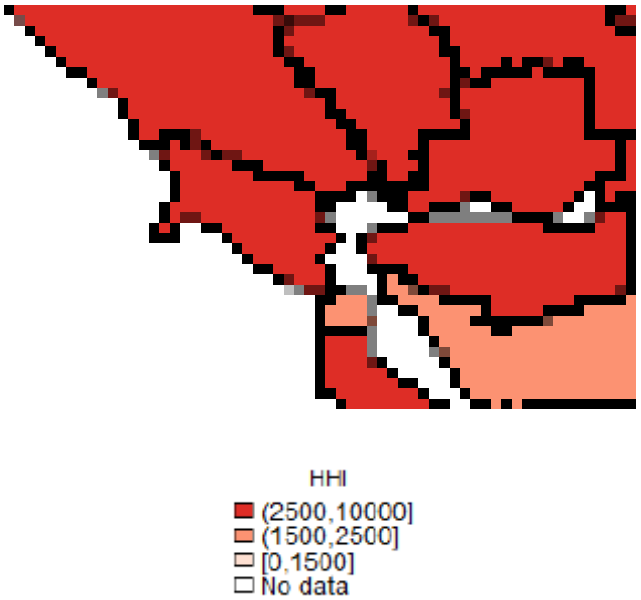
| | | **HHI Level in 2016** | | |
|---|---|---|---|---|
| | | < 1,500 | 1,500 to 2,500 | >2,500 |
| **HHI Change 2010 to 2016** | <100 | Low | Low | Low |
| | 100 to 200 | Low | Moderate | Moderate |
| | >200 | Low | Moderate | High |

*Low: "Unlikely to have adverse competitive effects and ordinarily require no further analysis"*
*Moderate: "Potentially raise significant competitive concerns and often warrant scrutiny"*
*High: "Presumed to be likely to enhance market power"*

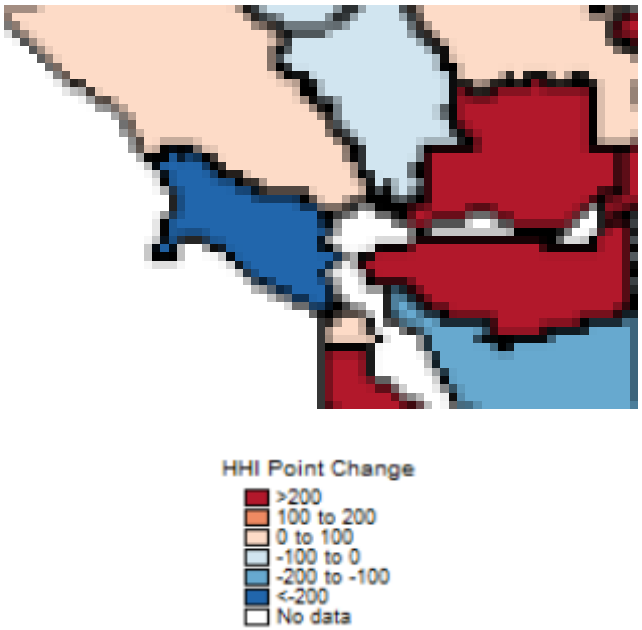
# San Francisco Market Concentration—Hospitals

- Utilizing the Herfindahl-Hirschman Index (HHI) we can see that San Francisco County has moderately concentrated markets (range of 1,500-2,500) in 2010 with minimal change to 2016

**2010**




**Change from 2010 – 2016**



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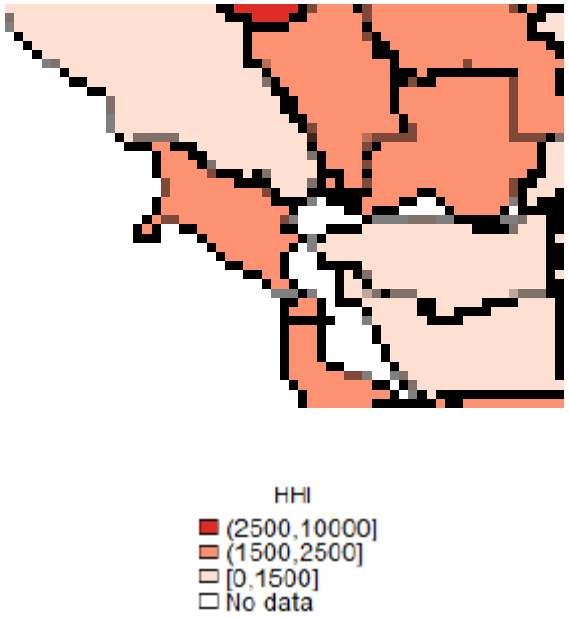
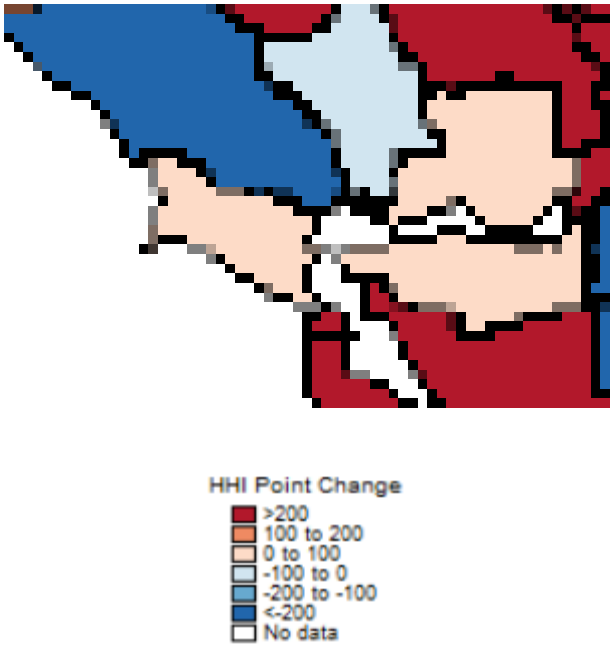
# San Francisco Market Concentration—Primary Care

- Utilizing the Herfindahl-Hirschman Index (HHI) we can see that San Francisco County has moderately concentrated markets (range of 1,500-2,500) in 2010 with significant consolidation to 2016

**2010**




**Change from 2010 – 2016**



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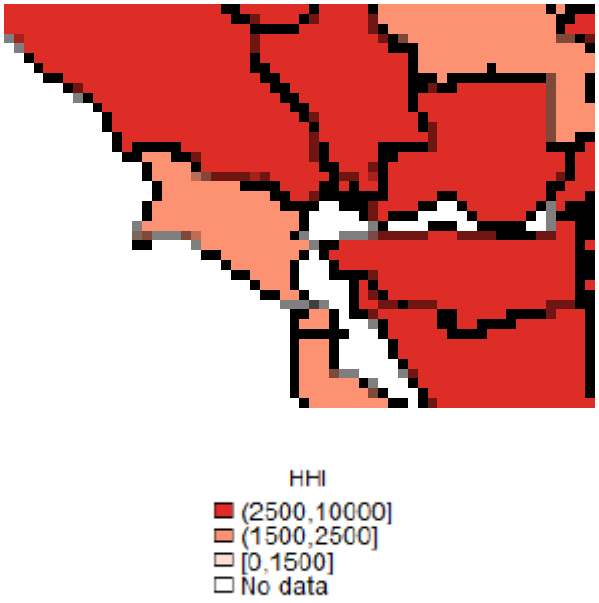
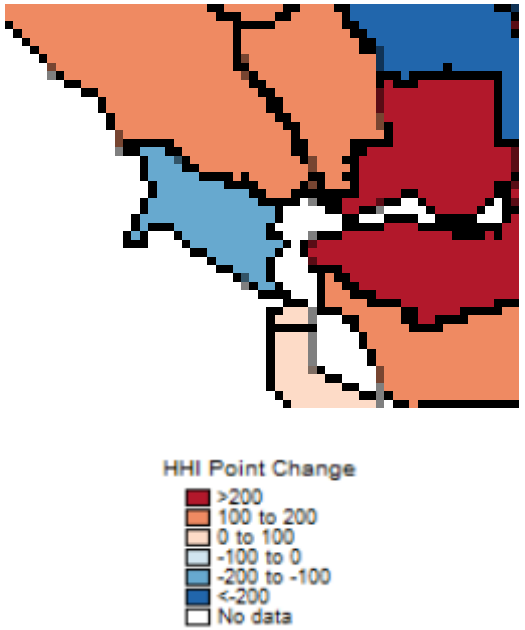
# San Francisco Market Concentration—Insurers

- Utilizing the Herfindahl-Hirschman Index (HHI) we can see that San Francisco County has moderately concentrated markets (range of 1,500-2,500) in 2010 with minimal change to 2016

**2010**




**Change from 2010 – 2016**



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# Sources

**Slide 7:**


[1] Largest Bay Area Hospitals Ranked by Average Number of Staffed Days, San Francisco Business Times (accessed July 9, 2019) https://www.bizjournals.com/sanfrancisco/subscriber-only/2018/12/07/largest-bay-area-hospitals.html

[2] California Health Care Foundation: Empire Building by the Bay: Consolidating Control of Hospitals and Physician Organizations in the Bay Area (2016) https://www.chcf.org/publication/empire-building-by-the-bay-consolidating-control-of-hospitals-and-physician-organizations-in-the-bay-area/?county=san_francisco#related-links-and-downloads


**Slide 13 — SFHSS Strategic Plan Goals:**
https://www.sfhss.org/resource/sfhss-2020-2022-strategic-plan

**Slide 14 — Triple Aim:**
http://www.ihi.org/Engage/Initiatives/TripleAim/Pages/default.aspx

**Slides 44-47 — Herfindahl-Hirschman Index:**
http://petris.org/wp-content/uploads/2018/03/CA-Consolidation-Full-Report_03.26.18.pdf