A Brief for the Board

Plan Year 2027 health coverage: what the record shows — and two rules for the decisions ahead

FRESNO COUNTY HEALTH COST WATCH · FOR THE FRESNO COUNTY BOARD OF SUPERVISORS · OCTOBER 28, 2026

From: Fresno Health Costs (fresnohealthcosts.com) — an independent watchdog project built entirely from documents the County of Fresno and the San Joaquin Valley Insurance Authority (SJVIA) published themselves

To: The Fresno County Board of Supervisors

Re: The Plan Year 2027 health renewal record — and the standards this brief asks the Board to apply to Plan Year 2028 and every renewal after it

Executive Summary

Executive summary, in written form. The spoken comment for the public-comment period is a separate two-minute text, filed with the one-page summary handout that accompanies this brief.

Chair Bredefeld, members of the Board — thank you.

I'm a Fresno County employee. I built Fresno Health Costs, an independent watchdog project, on one rule: use only the documents the County and SJVIA published themselves. Every number in this brief traces to one of those documents.

I'm not here about a single vote. On November 3, this Board takes up File 26-1229, the health contributions for management and unrepresented employees. I'm here about the votes that come after it — Plan Year 2028 and beyond — because this year's renewal record shows two things that went wrong, and both can be fixed by how the papers are prepared.

First: choices were made that were never weighed. The richest plan the County offered — the only one that told a family, however sick the year gets, your costs stop at $1,000 — was eliminated. No document in the public record prices keeping it. Not a rate. Not a buy-up. Nothing. In that same renewal, the health authority's reserves stood documented at more than twelve million dollars above its own safety targets — and that cushion was never weighed in the open against the cuts.

Second: nobody measured who would carry the increase. Premiums are flat dollars, but County pay is a ladder, and the people on that ladder answer the County's phones and staff its counters. The family premium in this record is $10,699 a year. That's 27.9 percent of an entry-level employee's gross pay; at the top of the schedule, it's 3.8 to 3 percent. Same dollar. It doesn't land the same. Measured against the County's own salary schedule, that premium sits above the federal affordability index — 10.22 percent — in 125 of 132 classifications. Nobody in this renewal ran that test.

So I'm asking you to adopt two rules for every health decision from here on.

> **Rule One: every option weighed.** No plan eliminated, no design changed, no cost shifted, until the alternatives are priced and printed side by side — the way a fiscal impact statement comes with every budget item.

> **Rule Two: no group carries an increase alone.** Every health item should carry, on its face, what it costs each group of employees as a share of their pay — so you decide who carries the burden, in the open, instead of it landing by default on the families with the least room in the check.

Three numbers, all from the public record. **$12,442,479** — reserves above the safety targets that were never weighed against the cuts. **27.9 percent against 3 percent** — the same premium at the bottom and the top of the ladder. And **125 of 132** — the classifications priced over the affordability index.

The records are public. They always were. This brief simply reads them in order.

Thank you.

1. The record of Plan Year 2027

The renewal was decided in a sequence of public actions: SJVIA's meetings of July 17 and August 21, 2026, its Kaiser actions of September 8, 2026, and this Board's premium approval of October 6, 2026 (File 26-0993). Read in order, the documents show a renewal in which the decisive analyses were never produced.

The rates were set with no margin — by the consultants' own account. USI's preliminary renewal report (July 17, 2026) states, in its own words: *"The 2026 medical premium equivalent rates did not include margin, thus making the annual budgeted accumulation $0 for the budgeted medical reserve."* Zero-margin rates convert one bad claims year into a shock renewal — and the bad year arrived: the same report records an eleven-month fiscal-year deficit of **$23,051,228**, and the County's File 26-1229 letter records a loss ratio of **108.6%** — $1.09 paid in claims for every $1 taken in. The crisis the redesign answered was substantially built by that pricing decision.

One renewal, three baselines, never reconciled. The same renewal is described as **+29.2%** (preliminary, blended — July 17, 2026), **+26.7%** (before plan-design strategies — USI final renewal letter, August 21, 2026), and **37%** (pre-redesign, self-insured plans only — File 26-1229). Each figure is real; their scopes differ, and no document prints them side by side with their scopes labeled — so the same redesign can be made to look three different sizes. The renewal as adopted landed at +16.55%.

Reserves were documented; design cuts were chosen anyway. SJVIA's cash-flow projections (May 1, 2026) document reserves, as of April 13, 2026, of **$12,442,479 above both** the plan's incurred-but-not-reported estimate ($10,613,090) **and** its three-month stabilization target ($20,741,256) — $5,442,479 after earmarks for a prior settlement. The final renewal applied approximately **$1.5 million** of reserves to reduce premiums by roughly two points (File 26-1229); permanent plan-design cuts did the rest of the work. No document in the record prices a larger reserve draw beside the cuts that were chosen.

A medication benefit was removed against the consultants' own written caution, on three unreconciled figures. USI's pharmacy report (August 21, 2026) priced anti-obesity medication at roughly $9.3 million gross and $5.6 million net of rebates, identified $1.62M–$1.73M in savings available inside the existing pharmacy spend, and warned, verbatim: *"If AOMs are excluded, member alternatives should be defined before the change."* The County's later letter prices the removal at approximately **$3.04 million** (File 26-1229) — a third figure, never reconciled with the first two. Removal was approved the same day the warning sat in the packet; no document defining alternatives appears in the record. The same authority's Kaiser program retained the same coverage for 2027 (September 8, 2026 packet).

The richest plan was eliminated, not repriced — and the cut spread. The August 21 redesign modified Sierra and Pismo — *"the addition of deductibles, adjustment of copays, and increased specialty pharmacy cost sharing"* — and eliminated the Yosemite EPO: *"Elimination of the Yosemite EPO $0 plan,"* the only design that capped a family's year at **$1,000** out of pocket. No document in the record prices keeping it: no standalone rate, no buy-up differential, no phased version. The cut then spread: USI's September 8, 2026 Kaiser letter aligned the insured HMO *"with the changes approved for the County's richest EPO plan,"* and the Plan Year 2027 Kaiser HMO now carries a $500/$1,000 deductible (Kaiser plan summary).

The analysis came from a firm six weeks into the engagement, unchecked. USI became SJVIA's consultant on June 1, 2026 and presented the preliminary renewal on July 17. The County's own RFP 26-074 sought an independent consultant expressly because USI had been selected as SJVIA's — the County documented the independence problem itself. No independent review of the renewal's numbers appears in the record.

Read together, these are six points in one process at which the analysis that would have informed the decision — a margin, a labeled baseline, a weighed reserve, a defined alternative, a priced option, an independent check — was never produced.

2. Rule One: Every option weighed

A board can only choose among the options that are put in front of it, priced. In Plan Year 2027, the decisive options never reached that form:

- The Yosemite EPO could have been **kept and priced on its own experience** — the rating practice SJVIA itself adopted in 2024 — with the County contribution pegged to a benchmark plan and enrollees paying the difference. No priced version of that option appears in any renewal document.

- The documented reserve cushion could have been **drawn down further**, or the redesign **phased over two years** — the staggered, reserve-smoothed approach the authority itself used for Plan Year 2026. Neither mix was priced beside the one adopted.
- The medication benefit could have been **managed** — prior authorization, step therapy, continuation criteria, the posture Kaiser kept in the same program — instead of removed. No managed alternative was priced beside the removal.

This brief does not ask the Board to re-decide Plan Year 2027. It asks that no future renewal be decidable in this form again.

The ask: an **options analysis attached to every future health action** — each plan elimination, design change, or cost shift presented with its alternatives priced and printed side by side: retention against elimination, reserve draw against design cut, phase-in against single-year cliff. The Board already requires this discipline everywhere else in the budget: no item reaches this dais without a fiscal impact statement. Health coverage — the largest benefit cost the County carries, felt in every paycheck — should not be the exception.

3. Rule Two: No group carries the increase alone

In every renewal document — the preliminary report, the final letter and tables, the pharmacy report, the Kaiser items, the County's board letters — there is no table, page, or paragraph breaking the renewal's cost by enrollment tier, job classification, income, or utilization, and no affordability test of any kind. The renewal was scored in aggregates: blended percentages, per-plan rates, pool totals.

Premiums, however, are not percentages. They are flat dollars charged against a pay ladder — 132 classifications in the County's own Salary Resolution. At the premiums this Board approved on October 6, 2026 and the contribution schedule in File 26-1229, the Kaiser HMO Family premium costs an employee **$10,699 a year** — one flat amount that is, as a share of gross pay:

Level (County Salary Resolution)	Share of gross pay
Office Assistant I / Social Worker Aide — entry step ($38,298/yr)	**27.9%**
Social Worker I	**16.4–21.0%**
Supervisor	**13.9–10.9%**
Program Manager	**10.5–8.2%**
Deputy Director	**7.1–5.6%**
Department Head	**5.3–4.2%**
County Administrative Officer	**3.8–3.0%**

Measured against the standard federal affordability benchmark — **10.22%** of income for plan years beginning in 2027 (Rev. Proc. 2026-26) — an audit of all 132 County classifications at midpoint salary finds the Kaiser HMO Family premium over that line in **125 of 132 classifications**. The index is the standard federal benchmark, used here as the measure of affordability against the County's own published salary schedule: the yardstick the renewal never picked up.

The redesign's weight landed the same way: its costs fell on employees who cover dependents and on employees who use care — deductibles added where none had existed, specialty cost-sharing raised, the one plan that capped a family's year eliminated. A family's worst-case year — premiums plus maximum out-of-pocket — now runs to **$17,083 (Cypress), $18,199 (Kaiser HMO), and $23,243 (Maple)**, in place of the $1,000 ceiling. At the top of the schedule, the same premiums are 3 to 4 cents of every pay dollar. No group was asked to carry this increase alone in so many words. The documents show that is how it was carried.

The asks: a **household-impact statement on the face of every future health item** — the item's cost by classification and enrollment tier, scored against the federal affordability index, printed where the fiscal impact statement sits now; and **burden-sharing structures evaluated as standing options** in every renewal — including contribution designs tied to a percentage of pay — so that who carries an increase is a decision this Board makes in the open, not a default the flat dollar makes in silence.

4. What the Board is asked to adopt

For Plan Year 2028 and beyond, this brief asks the Board to adopt three standing practices:

- **Every option weighed.** No health action — plan elimination, design change, or cost shift, at SJVIA or in a County contribution item — is approved without an options analysis: the alternatives priced and printed side by side in the item itself.
- **No group carries the increase alone.** Every health item carries a household-impact statement — cost by classification and tier as a share of pay, scored against the federal affordability index — and burden-sharing designs are evaluated as standing options, so incidence is decided, not defaulted.
- **The working papers published with the packet.** The consultant reports a packet relies on should be posted with the packet that cites them — beginning with the full USI final renewal report of August 21, 2026, the document that prices, or fails to price, every option in this brief. A conclusion the public cannot check is one it is asked to take on trust, and this renewal shows where that leads.

File 26-1229, before this Board on November 3, applies the same flat contribution schedule at every level of the pay ladder. Whatever the Board decides on that item, the two rules are how the items after it can be decided better: with every option on the table, and every burden in plain sight.

Fresno Health Costs will keep reading the record in public, in order, from the documents themselves.

The records are public. The responsibility is orphaned.

Sources: USI preliminary renewal report, SJVIA, July 17, 2026; SJVIA Board renewal actions, July 17 and August 21, 2026 (final renewal letter; Item 11 pharmacy report); SJVIA cash-flow projections, May 1, 2026 (reserve position as of April 13, 2026); SJVIA staggered renewal action (Option 3A), August 27, 2025; USI Kaiser letter and SJVIA packet, September 8, 2026; Fresno County Legistar Files 26-0993 (October 6, 2026) and 26-1229 (Board agenda, November 3, 2026, Item 9); Board-approved Plan Year 2027 rate sheet (October 6, 2026) and plan summaries (Kaiser HMO; Anthem Cypress and Maple); Fresno County Salary Resolution §100, Alphabetical Position Listing (updated August 3, 2026); County of Fresno RFP 26-074; IRS Rev. Proc. 2026-26 (federal affordability benchmark, 10.22%). Classification affordability audit and premium-to-pay calculations: Fresno Health Costs, run on the County's published salary schedule and the Board-approved premiums above. Salary figures are published pay-range amounts (entry step, midpoint, top step), not any individual employee's actual pay.

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