TURN DATA REQUEST-070
SDG&E-SOCALGAS 2019 GRC – A.17-10-007/8
SDG&E_SOCALGAS RESPONSE
DATE RECEIVED: JUNE 27, 2018
DATE RESPONDED: JULY 17, 2018

1. The SRE utilities state at p. DSR-32 (lines 6-8, 11-12) of SCG-230/SDG&E-228, "The unit cost of health care (medical and pharmacy) and the rate of cost increases is most accurately determined by the local health care market.SoCalGas' and SDG&E's escalation rates reflect the markets where the enrolled employees and their dependents receive health care services, which is primarilySouthern California. Other data sources report national trends. Projected nationalcost increases are not directly relevant to SoCalGas and SDG&E projected increases."

a. Please provide any evidence that supports the utilities' conclusion that the rate of increase of healthcare costs in Southern California are expected to be higher than national averages.

Utility Response 1:

SoCalGas and SDG&E object to this request to the extent that it seeks information not within their possession or control. SoCalGas and SDG&E relied on a medical trend forecast prepared by Willis Towers Watson, as described in SCG-30/SDG&E-28 at p. DSR-30. Subject to and without waiving this objection, SoCalGas and SDG&E respond as follows:

SCG-30/SDG&E-28 provides testimonial evidence regarding the factors that were considered by Willis Towers Watson in determining a proposed medical escalation rate in this case, including factors related to the Southern California market. Geographic location is not the only factor that would contribute to a difference in medical escalation, as described in Ms. Robinson's testimony.

Additionally, SoCalGas and SDG&E already capture the cost efficiencies that are increasingly being utilized outside of California. Specifically, SoCalGas and SDG&E leverage capitated HMOs in Southern California to provide cost-effective care. The national market is moving away from fee for service to more alternative provider reimbursement methods more closely aligned with the concepts embedded in captitated or staff models. This transition in provider reimbursement should dampen the medical cost escalation in the national market. Because SoCalGas and SDG&E already leverage capitated and staff model HMOs, this source of cost escalation mitigation is not available to SoCalGas and SDG&E in the same degree.

Similarly, SoCalGas and SDG&E already have the vast majority of non-HMO enrollment in the Anthem HealthCare Plus high-deductible health plan. The national market is still benefiting from a slow migration from traditional preferred provider organization (PPO) designs to high-deductible health plan designs. Because SoCalGas and SDG&E already leverage the benefit of a high deductible health plan, this source of national medical cost escalation mitigation is not available to SoCalGas and SDG&E.

Utility Response 1 Continued:

Willis Towers Watson additionally estimates that, all things being equal, the average increase in "per participant per year" plan cost from 2017 to 2018 was approximately 0.5% higher for California than the national average.

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2. The SRE utilities state at p. DSR-32 (lines 21-22) of SCG-230/SDG&E-228, "Older age generally results in higher cost and a faster rate of increase if all else is equal."

a. Please provide evidence that supports the statement, "[o]lder age generally results in…a faster rate of increase."

b. Please provide any evidence, if available, that it is reasonable to expect that the average age of SCG/SDG&E employees will be higher in the test year as compared to 2016.

c. If the SRE utilities expect the average age of employees to be higher in 2019 than in 2016, please explain why this is so. Please address this expectation given the new hires that the utilities proposes to make as a result of their stated need and the employee count increase between 2016 and 2019 shown within the GRC testimony and workpapers.

Utility Response 2a:

The full sentence from Ms. Robinson's rebuttal testimony that TURN references above is "Older age generally results in higher cost and a faster rate of increase if all else is equal." The attached PWC Medical Cost Trend: Behind the Numbers 2019 report identifies age as a key driver of medical cost trend increases.[1] The relationship between medical costs and age also is reflected in:

- The claim cost age curve disclosed in SoCalGas' and SDG&E's postretirement welfare reports, which were provided to TURN in the Companies' response to TURN-SEU-DR-005 Q1; and
- A similar cost age curve used by the public exchanges where premium for the oldest age band are artificially limited to 3x the premium for the youngest age band. A 5x ratio was frequently cited during the Affordable Care Act (ACA) debates as a more realistic ratio to avoid the young subsidizing the old.

Utility Response 2 Continued:

[1] PWC Medical Cost Trend: Behind the Numbers 2019 report, p. 8.

The PWC Medical Cost Trend: Behind the Numbers 2019 report also identifies drug spending and medical technology/innovation as key drivers of medical cost trend.

Older people generally incur higher drug spending, as shown below in data from the Health Care Cost Institute (HCCI). Since drug spend is a major driver of medical cost escalation, an older population tends to drive higher medical cost escalation.

- HCCI Data for Annual Prescription Costs per Person per Age Group[2]

Prescriptions	
Age	**2016**
Ages <19	$418
Ages 19-25	$500
Ages 26-44	$519
Ages 45-54	$1,492
Ages 55-64	$2,171

Most technology/innovation will be reflected in costs of inpatient care (or drug costs) since an in-patient setting is the most capital intensive. Using the HCCI data again, people in older ages have larger inpatient costs and therefore higher medical costs.

- Annual cost per person per age group[3]

Inpatient	
Age	**2016**
Ages <19	$660
Ages 19-25	$575
Ages 26-44	$860
Ages 45-54	$1,186
Ages 55-64	$2,139

[2] http://www.healthcostinstitute.org/report/2016-health-care-cost-utilization-report/, Excel Data Tables, Table A12.

[3] http://www.healthcostinstitute.org/report/2016-health-care-cost-utilization-report/, Excel Data Tables, Table A12.

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Utility Response 2b and 2c:

TURN requests that the Companies "provide any evidence, if available, that it is reasonable to expect that the average age of SCG/SDG&E employees will be higher in the test year as compared to 2016". Ms. Robinson's testimony does not assert that the aveage age of employees enrolled in the Companies' medical plans will be higher in the 2019 Test Year than in 2016.

Rather, Ms. Robinson references the fact that the average age of active employees enrolled in the companies' medical plans (47.0 years) is higher than the average age of employees included in Willis Towers Watson's benefits database (44.8 years). To the extent that the average age of employees enrolled in the Companies' medical plans is higher than the average age of the population included in the Willis Towers Watson database and other surveys, the age differential will tend to contribute to higher medical cost escalation, as older age generally results in a higher cost and faster rate of increase if all else is equal.