SFHSS Staff Request for Proposal (RFP) Recommendation for the Medicare Plan MAPD (Medicare Advantage Prescription Drug) Passive PPO for the 2025 Plan Year:

Add the Blue Shield of California (BSC) Medicare Advantage Prescription Drug (MAPD) Passive PPO plan for Medicare Members, and offer the existing BSC HMO (Access+/Trio) and PPO plans to Non-Medicare "split family" covered lives in families with at least one covered MAPD Passive PPO plan covered life—with the 2025 plan year rate cards contained in this material; and Discontinue the UnitedHealthcare (UHC) MAPD Passive PPO plan, UHC non-Medicare Select EPO plan, UHC non-Medicare Doctors EPO plan, and UHC non-Medicare PPO plan.

June 7, 2024

Presenters:

Abbie Yant, RN, MA Executive Director, SFHSS
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SAN FRANCISCO
HEALTH SERVICE SYSTEM

Affordable, Quality Benefits & Well-Being

Introduction

Agenda

- Staff Recommendation
- RFP Process: History, Framework, Objectives and Scope
- Development of Scoring and RFP Elements
- Evaluation Panel and Subject-Matter Expertise and Support
- Why We Recommend Blue Shield of California: RFP Scoring and Framework
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- 2025 Plan Year Rate Cards for Recommended Plans
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Staff Recommendation to the Health Service Board (HSB): Medicare Advantage Prescription Drug (MAPD) PPO RFP

Staff Recommendation

Approve, effective January 1, 2025:

Add the Blue Shield of California (BSC) Medicare Advantage Prescription Drug (MAPD) PPO plan for Medicare Members, and offer non-Medicare UnitedHealthcare Members the existing BSC HMO (Access+/Trio) and PPO plans—with the 2025 plan year rate cards contained in this material; and

Discontinue the UnitedHealthcare (UHC) MAPD PPO plan, UHC non-Medicare Select EPO plan, UHC non-Medicare Doctors EPO plan, and UHC non-Medicare PPO plan.

Recommended 2025 Health Plan Offerings for Medicare Members and Families With At Least One Medicare Dependent

Medicare-eligible	Non-Medicare-eligible lives of "Split Families"[1]
BSC Medicare Advantage PPO **(transition from UHC effective January 1, 2025)**	BSC Access+ HMO BSC Trio HMO BSC Non-Medicare PPO **(transition from UHC effective January 1, 2025)**
Kaiser Permanente Senior Advantage (KPSA) HMO (CA, OR, NW, HI coverage areas only)	Kaiser Permanente HMO (CA, OR, NW, HI coverage areas only)
Blue Shield of California PPO-20 Plan	*No dependent coverage available*

[1] "Split Families" have at least one covered life who is Non-Medicare and one covered life who is Medicare, among the Member and dependent(s) in the family.

RFP Process
History, Framework, Objectives and Scope

Lead up to HSS Medicare RFP (overview)

2020-2021: Education and discussion of Medicare plans; HSS Medicare plan history; marketplace and trend monitoring.

2021: Discussion of potential Medicare RFP (for PY2023); Evaluated through 2021 Medicare RFI (Sept. – Dec.).

2022-2023: Evaluate Healthcare Cost Trend Influencers (February and May 2023); revisited Medicare market and trends.

2023-2024: Evaluate, discuss and narrow scope of potential PY2025 Medicare RFP (Aug. – Nov. 2023); issued Medicare RFP (Dec. 12, 2023); analysis, evaluation and panel discussion (Feb. – April 2024); present results of Medicare RFP to HSB for discussion and approval (June 7, 2024).

HSS Medicare RFP History (Nov. 2020 – Aug. 2023)

- Medicare Plan Market Update, Aon (November 12, 2020)
- Evaluation and discussion of a PY2023 Medicare RFP (June 10 and August 12, 2021)
- Announcement of Medicare RFI (September 9, 2021)
- Review Process and Findings Regarding Market for Medicare Advantage Plans and RFI (December 9, 2021)
- Healthcare Cost Trend Influencers (February 9, 2023)
- Healthcare Cost Trend Influencers - Update (May 11, 2023)
- Annual HSS/HSB Competitive Bids and Healthcare Ecosystem and Market Review (August 10, 2023)

HSS Medicare RFP Process (Aug. 2023 – Dec. 2023)

- Input from HSB and stakeholders; development of scope and objectives, announcement of PY2025 MAPD RFP (August - November 2023).
- Presentation of RFP Objectives and Scope (November 9, 2023).
- RFP Issued:
  - Public-facing RFP Document (December 12, 2023)
  - Notified Medicare carriers (December 12, 2023)
  - Executed mutual confidentiality agreements; provided access to deidentified data (December 15 - 19 2023).

HSS Medicare RFP Process (2024)

- Addenda, requests for clarification, questions (Jan. – April 2024)
- Evaluation panel vetting and selection (Dec. 2023 – Feb. 2024)
- Confirmation of Minimum Qualification to Bid (February 9, 2024)
- RFP scoring rubric finalized (February 14, 2024)
- Opening Non-Financial Responses (February 15, 2024)
  - Analysis (pharmacy, network, PGs) (Feb. 15 – Mar. 11, 2024)
  - Non-financial Panel Discussions (March 11 – April 26, 2024)
- Analysis of Financial Reponses (April 9 - 26, 2024)

Medicare RFP Scope *(presented November 9, 2023)*

- PPO population (17,309 covered lives)
- Medicare (Part A & B; Part B Only)
- Three- to five-year rate commitment
- Non-Medicare “Companion” (split-family) plan administration
- Robust and stable provider network
- CMS innovation and value-added programs (meals, transportation, OTC allowance, dental, fitness programs)
- Comparable formulary and assessment of alternative formulary approaches
- Increased transparency into rates, costs, CMS revenue amounts and claims

Medicare RFP Scope (cont.) *(presented November 9, 2023)*

- Best-in-class:
  - Medical care management
  - Preauthorization/utilization management
  - Concurrent review (inpatient)
  - Case, demand, population, disease and co-morbidity management
- Experience in transitioning retirees and their dependents to Medicare
- Support SFHSS in Member-outreach prior to Medicare eligibility
- Leading subject-matter expertise in Medicare plan administration

Medicare RFP Objectives

- Alignment with and support for the SFHSS Strategic Plan.
- Substantive impact to City budget and participating Employers' and Members' contributions with a minimum three (3) year rate commitment.
- Minimal network and formulary disruption.
- Match current benefit design.
- Effective administration of companion plans for split-families.
- Experienced account management in Medicare Member outreach and communications, and Medicare transitioning for non-Medicare retirees and their dependents.

Medicare RFP Requirements to Bid

- Have at least 100,000 covered lives in Medicare Advantage programs.
- Have at least one (1) client with over 10,000 covered lives.
- Have at least five (5) years of experience offering Medicare Advantage plans.
- Offer a Part B Only Medicare Advantage Plan.
- Support SFHSS operational file requirements.

Setting a High Bar for Entry to HSS Medicare RFP

Final Respondents (3)

Met requirements to bid;
intent to bid / executed MCA; addenda Q&A (5)

Experienced with Group Medicare Advantage* (12)

Experienced Medicare Advantage Carriers in California* (28)

* Data collected based on CMS Enrollment Files

RFP Evaluation Panel and Subject-Matter Expertise

RFP Evaluation Panel:

- Outreach and evaluation of expertise and experience
- Impartiality and Confidentiality (IC Statements)
- Panel review topics: Medicare trends, HSS plan history, RFP process and history, stakeholders, Member experience.
- Balanced composition (six-member panel across varied entities: HSS (2), City (2), External (2)).
- Review, discussion and scoring of non-financial and financial scoring elements including oral interviews.

Expert Consultation:

- The panel was supported by our Core Aon team for HSS (including Anne Thompson and Mike Clarke), as well as Medicare subject-matter experts within Aon (Maridale Goff and Garrett Pagonis) – including Aon calculation of quantifiable scoring elements.

Why We Recommend Blue Shield of California: Scoring and Framework

Medicare RFP Components

Item	Possible Points
Premiums	**60**
Medicare Premium Rates	40
Medicare Future Premiums	20
Other Financial	**18**
Medicare Gain Sharing Agreement	8
Medicare Performance Guarantees	5
Caveats	0
Implementation and Audit Credits	5
Non-Financial	**54**
Plan Design	5
Star Ratings	5
Questionnaire	20
Provider Network	10
Formulary Disruption	12
Pharmacy Network Disruption	2
Commercial (split-family) (Questionnaire – 4; Pricing – 2; Provider – 1; Formulary – 1)	**8**
Oral Interview (Medicare & Non-Medicare)	**20**
Total	**160**

Medicare RFP Scoring: Categories and Possible Points

Scoring Category	Possible Points	%
Financial - Premiums	60	37.5%
Financial - Other	18	11.25%
Non-Financial - MAPD Capabilities	54	33.75%
Non-Financial - Commercial Capabilities (split-family)	8	5%
Non-Financial - Oral Interview	20	12.5%
Total	160	100%

Medicare RFP: Final Scoring

Total Possible Points	UHC	BSC	Anthem
160	102.96	**115.96**	86.71
Rank	2	**1**	3

Final Scoring (cont.)

Item	Possible Points	UHC Points	BSC Points	Anthem Points
Premiums	**60**	**18.94**	**54.00**	**20.65**
Medicare Premium Rates	40	18.67	40.00	16.46
Medicare Future Premiums	20	0.27	14.00	4.19
Other Financial	**18**	**14.5**	**9.98**	**9.94**
Medicare Gain Sharing Agreement	8	5.60	4.48	2.40
Medicare Performance Guarantees	5	5.00	0.50	2.75
Caveats	0	-0.19	0.00	-0.21
Implementation and Audit Credits	5	4.09	5.00	5.00
Non-Financial	**54**	**50.06**	**36.09**	**38.23**
Plan Design	5	4.90	4.47	4.92
Star Ratings	5	4.50	0.00	3.50
Questionnaire	20	17.39	14.31	14.24
Provider Network	10	9.56	4.27	7.06
Formulary Disruption	12	11.71	11.11	6.52
Pharmacy Network Disruption	2	2.00	1.94	1.99
Commercial (split-family)	**8**	**5.15**	**4.73**	**5.81**
Questionnaire	4	3.16	3.36	2.73
Pricing	2	0.00	0.00	1.80
Provider Disruption	1	1.00	1.00	1.00
Formulary Disruption	1	0.99	0.37	0.28
Oral Interview	**20**	**14.31**	**11.17**	**12.08**
Medicare & Non-Medicare	20	14.31	11.17	12.08
Total	**160**	**102.96**	**115.96**	**86.71**

Financial Elements

Financial Elements: Cost Comparison

BSC's MAPD PPO financial proposal is projected to save as much as $67M ($7.8M of this for Members) over the incumbent proposal from 2025-2027.[1]

Annual Financial Projections[2]	2025	2026	2027	Projected 3-Year Total
BSC	$114,900,000	$120,100,000	$127,900,000	$362,900,000
UHC[1]	$127,200,000	$143,300,000	$159,400,000	$429,900,000
BSC/UHC Difference	**$12,300,000**	**$23,200,000**	**$31,500,000**	**$67,000,000**
Anthem[1]	$128,400,000	$137,000,000	$145,600,000	$411,100,000
BSC/Anthem Difference	**$13,500,000**	**$17,000,000**	**$17,800,000**	**$48,200,000**

[1] UHC and Anthem provided rate increase caps for 2026 and 2027. For calculation and scoring purposes, the rate increase caps were used.

[2] Financial projection figures rounded to the nearest $100,000.

Financial Elements: Gross Per-Member-Per-Month Premium

Medical Only Premium Table (PMPM)	2024	2025	2026	2027
UnitedHealthcare (UHC) Current (2024) / *UHC RFP Response (2025-2027)*[1]				
Parts A & B	$514.31	*$586.82*	*$661.82*	*$736.82*
Part B Only	$897.14	*$1,023.64*	*$1,098.64*	*$1,173.64*
Blue Shield of California (BSC) RFP Response				
Parts A & B[1]		$534.37	$558.41	$594.71
Part B Only[1]		$534.37	$558.41	$594.71

	2025 Increase (Over Current)	2026 Increase (Over 2025 Quote)	2027 Increase (Over 2026 Quote)
BSC	3.1%	4.5%	6.5%
UHC (Parts A & B)	14.1%	12.8%	11.3%

[1] UHC quoted not-to-exceed premium increases for 2026 and 2027

[2] BSC provided a blended rate for Part A&B and Part B Only Members.

Financial Elements: 2025 Retiree Contribution Impact—Based on MAPD PPO Rate Differential Between BSC and UHC

- Members covering Medicare dependents will pay less in Member contributions in 2025 with BSC than they would with UHC—in aggregate, $1.2M of the total $12.3M premium difference.

Family Type	Annual Per Member Contribution Savings, BSC vs. UHC	Member Count	Aggregate 2025 Member Contribution Savings, BSC vs. UHC
Medicare 2-Party; Non-Medicare Retiree with Medicare Dependent	($314.64)	3,845	($1,209,791)
Medicare 3+; Non-Medicare Retiree with 2+ Medicare Dependents	($944.04)	10	($9,440)
Total		3,855	($1,219,231)

- Those receiving less than the full City Charter employer contribution (e.g., those hired on/after January 9, 2009, with less than 20 years of service) will also have lower Member contributions—there are currently 151 such covered Members.

Non-Premium Financial Elements

- **Caveats:** Exceptions that allow carriers to change multi-year agreements (Legislative/Regulatory Changes, New Drugs, Membership).
- **Medicare Gain Sharing Agreement:** If plan performs better than expected a portion of premiums are returned to the plan sponsor.
- **Performance Guarantees**
  - Primary care, mental health, non-contracted providers, reporting and transparency.
  - 2% fees-at-risk requested.
- **Implementation and Audit Credits:** Dollars provided to support change management and audit rights.

Non-Financial Elements: Member Experience

Non-Financial Elements: Member Experience (overview)

- SFHSS focused on alignment with Strategic Plan goals and Member experience.

- Key (non-financial) areas of focus for the RFP:
  - Plan Design
  - Star Rating
  - Formulary
  - Provider Network
  - Pharmacy Network
  - Questionnaire (100+ questions)
    - Administrative Support
    - Partnership with Providers
    - Transparency
  - Oral Interviews

Non-Financial Elements: Member Experience – Key Components

Component	Description
Passive PPO: Same cost share in and out of network	Passive PPO required to bid
Plan Design: Closely replicate core medical, supplement and pharmacy design.	Closely replicate core medical, supplemental benefits, and pharmacy; Plan design is not filed with CMS
Provider Network Match: Reviewed 2022 and 2023 claims for provider, facilities and ancillary match.	Looked at contracted providers (CP) and non-contracted providers with a history (NCH) of accepting the plan
Formulary Match: Formulary that covers all Part D drugs and select non-Part D drugs.	Less than 2% absolute disruption; RFP evaluated both tier and absolute formulary disruption
Pharmacy Network: Broad based pharmacy network	No bidder exceed 0.05% pharmacy network disruption
Star Ratings: CMS ratings	Looked at current and historical ratings

Non-Financial Elements: Plan Design

RFP Respondents were directed to match current plan designs.

70 — Medical Benefit Design Elements
(deductible, copays, out of pocket max, hospital, Part B drugs, therapy, preventative)

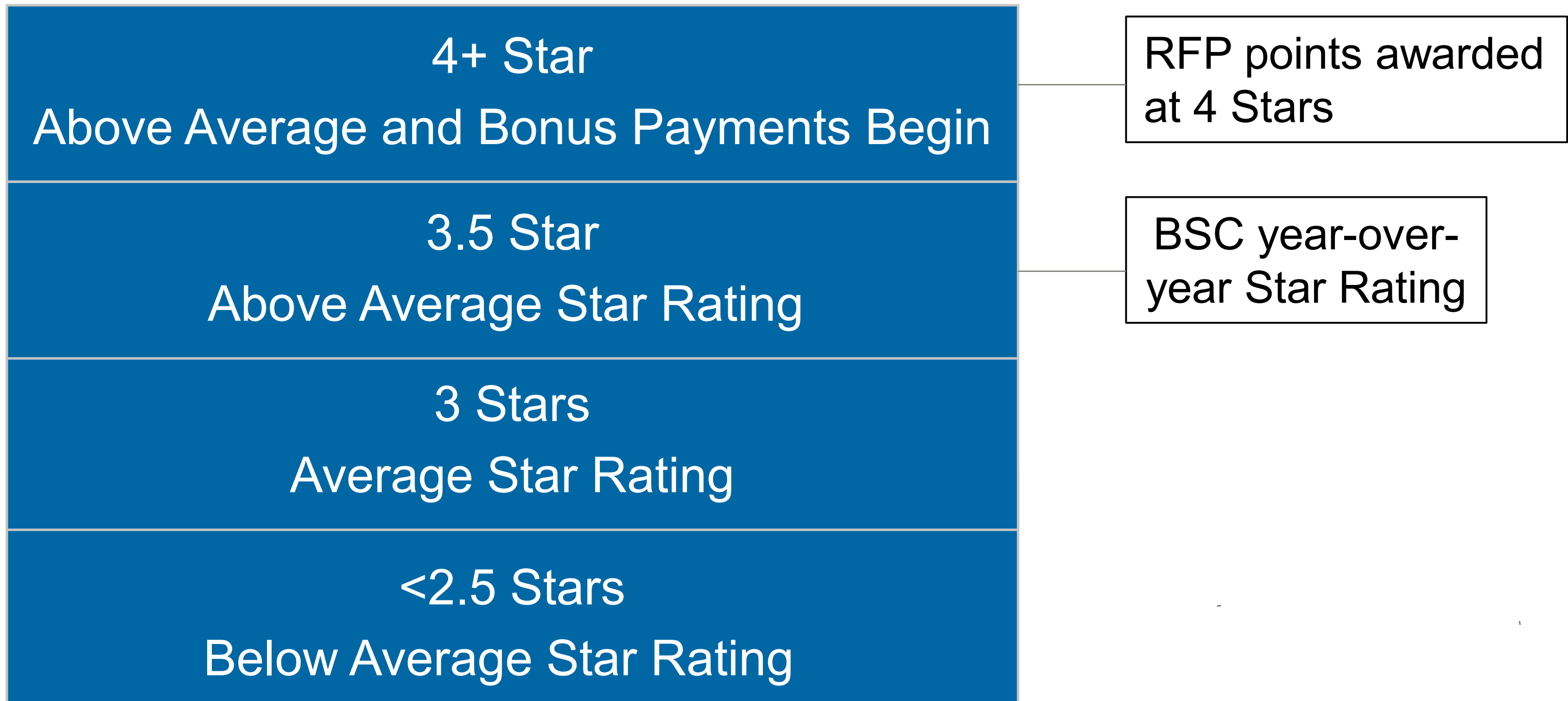
10 — Pharmacy Design Elements
(deductible, out of pocket max, copays retail and mail)

8 — Supplemental
(fitness, meals, hearing aids, transportation, coaching, personal emergency)

Non-Financial Elements: Star Rating

- The Centers for Medicare & Medicaid (CMS) Star Ratings process is an ongoing process designed to provide annual feedback to health plans.
- Feedback is based on CMS designated domains.
- Each year CMS may change the measurements and cut points for scoring.

Non-Financial Elements: Star Rating (cont.)



Non-Financial Elements: Provider Network

- Measuring ability for Members to maintain their patient-provider relationships was a very important component within the RFP.
- As such, the RFP required a Passive PPO plan approach.
- SFHSS used 2022 and 2023 claims and claim dollars to understand the impact.
- **The next slides show how a Passive PPO product works.**

Non-Financial Elements: Provider Network (cont.) Medical Provider Utilization Analysis – Considerations

National Open Access "Passive PPO'

Allows Members to see **any willing provider participating in the Medicare program,** with no network steerage, restrictions, or plan design penalties.

As a result, **“provider disruption” in the traditional sense is not the same** when transitioning from one Medicare Advantage plan to another Medicare Advantage plan.

Considerations

- Members have access to contracted and non-contracted providers.
- Non-contracted providers who accept Medicare Advantage Members receive the **same reimbursement** as they would receive under Original/Traditional Medicare.
- Contracted providers receive the rate they negotiate with the plan and must abide by the terms of their negotiated contract.

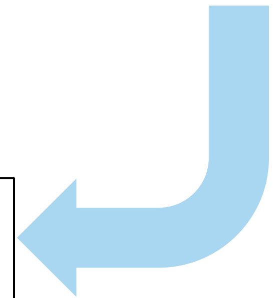
Non-Financial Elements: Provider Network (cont.) Medical Provider Utilization Analysis – Methodology

- Using the 2022 and 2023 SFHSS medical provider utilization data, we asked each carrier to indicate the provider's current "status" with respect to the 2023 Medicare Advantage PPO medical network supporting the carrier's proposal, using the following codes:

CP **Contracted Provider**	**NCH** Not Contracted, but **has a history of accepting** the plan within the last 12 months	**NCNH** Not Contracted, and **does not have a history** of accepting the plan within the last 12 months

  - Typically, if a provider accepts Original/Traditional Medicare a provider will accept a Medicare Advantage plan on a non-contracted basis because they are reimbursed at the same rate as Original/Traditional Medicare.

The carriers will generally outreach to these providers to educate them on the open access MA PPO product and payment methodology.



Non-Financial Elements: Provider Network (cont.) Medical Provider Utilization Analysis – Results Summary

- RFP analysis is a point-in-time analysis. Scored based on data returned.
- Best results expected with incumbent (UHC paid claims used for baseline).
- Post-analysis clarifications further increased the CP+NCH for the recommendation.
- CP+NCH (%) expected to further increase during implementation.

	Percentage of Medical Claims Dollars			
Carrier	**2023**		**2023 w/ Ongoing Review**	
	CP	CP + NCH	CP	CP + NCH
UHC	95%	100%	95%	100%
BSC[1]	82%	82%	83%	94%
Anthem	77%	96%	77%	96%

[1] During the RFP, BSC did not provide data for NCH providers. BSC's RFP scores reflect that.

Non-Financial Elements: Provider Network (cont.)
Medical Utilization Analysis – Top 10 Facilities

Facility	City	State	Network Status	
			UHC	BSC
UCSF MEDICAL CENTER	SAN FRANCISCO	CA	CP	CP
CA PACIFIC MEDICAL CENTER VAN NESS CAMPUS	SAN FRANCISCO	CA	CP	CP
MILLS-PENINSULA MEDICAL CENTER	BURLINGAME	CA	CP	CP
STANFORD MEDICAL CENTER	STANFORD	CA	NCH	NCH
ST. MARY'S MEDICAL CENTER	SAN FRANCISCO	CA	CP	CP
CALIFORNIA PACIFIC MEDICAL CENTER MISSION	SAN FRANCISCO	CA	CP	CP
MARINHEALTH MEDICAL CENTER	GREENBRAE	CA	NCH	NCH
SAN FRANCISCO GENERAL HOSPITAL	SAN FRANCISCO	CA	CP	NCH
CA PACIFIC MEDICAL CENTER DAVIES CAMPUS	SAN FRANCISCO	CA	CP	CP
SUTTER VISITING NURSE ASSOC. AND HOSPICE	ROSEVILLE	CA	CP	CP

CP – Contracted Provider; NCH – Non-Contracted with a History of Accepting
Top 10 Providers represented based on 2023 claims dollars (out of **2,964** total facilities).

Non-Financial Elements: Provider Network (cont.)
Medical Utilization Analysis – Top 10 Providers

Provider	Network Status	
	UHC	BSC
PACIFIC INPATIENT MEDICAL GROUP INC.	CP	CP
BROWN AND TOLAND LLC.	CP	CP
UCSF PHYSICIAN GROUP	CP	CP
UCSF CLINICAL INTEGRATED PARTNERS	CP	CP
CEP AMERICA CALIFORNIA A CALIFORNIA GENE	CP	CP
UCSF MEDICAL CENTER	CP	CP
UCSF DEPT. OF MEDICINE	CP	CP
UCSF MEDICAL GROUP BUSINESS SERVICE	CP	CP
UCSF MEDICAL CENTER/PROF. FEES	CP	CP
SAN FRANCISCO EMERGENCY MEDICAL ASSOCIATION	CP	CP

CP – Contracted Provider
Top 10 Providers represented based on 2023 claims dollars (out of **9,515** total providers).

Non-Financial Elements: Pharmacy Network

- SFHSS also wanted to ensure Members have access to their same prescription drugs at the same pharmacies.
- This is an important element—however, typically disruption of pharmacy network is very minimal, which is true for BSC's pharmacy network.
  - **36** pharmacies out of **7,636** utilized by HSS Members in 2023 were reported as not in BSC's network—representing only **0.24%** of scripts (or less than 1 out of 400).

Full pharmacy network evaluation results in Appendix.

Non-Financial Elements: Pharmacy Network (cont.)
Pharmacy Network Analysis – Top Pharmacy Chains

- All proposed networks contain greater than 64,000 pharmacies.
- Majority of disrupted pharmacies are independent and do not participate in Medicare Part D networks across some carriers.
- Based on the pharmacy analysis the following pharmacy chains are currently in the UHC and BSC network:

Top Pharmacy Chains	
Costco	Safeway
CVS	Sam's Club
Kroger	Vons (Albertsons)
Lucky (Save Mart)	Walgreens
Rite Aid	Walmart

Non-Financial Elements: Formulary

- A **formulary** is the list of drugs that is available under the plan.
- No two carriers will have the same formulary. Even the incumbent will have year-over-year formulary changes.
- Access to prescription drugs is a focus for Members and thus for HSS—and large changes can create Member concern.
- Our goal was to limit both negative tier changes (paying more) and absolute disruption (can't get drugs)—the RFP measured both.
- HSS also ensured transition fills would be available during implementation, for the rare situations where a drug is not on the formulary in the future.

Non-Financial Elements: Formulary (cont.)

- Most recent year of retiree drug scripts used as baseline (incumbent claims and formulary).
- Respondents asked on a script level to share if the script would be available and tier.
- There will be also be positive disruption (certain drugs cost less in the future): 5,209 scripts (0.7%) for 106 drugs.

	2023 Total Scripts	Negative Disruption	Percentage
UHC Tier Changes	791,404	0	0%
UHC Tier Changes (HIV)	791,404	0	0%
UHC Absolute (Not on Formulary)	791,404	847	0.11%
BSC Tier Changes	791,404	17,001	2.15%
BSC Tier Changes (HIV)	791,404	727	0.09%
BSC Absolute (Not on Formulary)	791,404	332	0.04%

Non-Financial Elements: Questionnaire

Subject areas for the Non-Financial Questionnaire:

- Medicare Advantage Capabilities and Strategy
- Provider Engagement and Network Adequacy
- Case Management and Utilization Management
- MAPD Transition, Support, Implementation Manager
- Technical (Administration/Data) Questions, Ongoing Admin.
- Split-Family Support (approach to administration)
- Non-calculable financial questions (rate methodology, IRA)

Oral Interviews

- HSS conducts oral interviews in RFPs to assess the quality and capabilities of the proposed account management team and subject-matter experts for each respondent.

- Interview content aligns with Member needs, Strategic Plan goals and objectives, and support for HSS.

	UHC	BSC	Anthem
Score (%)	81.27	71.76	70.25
Rank	1	2	3

- UHC (incumbent) able to draw on experience with Members and HSS. This created a 10% differential in scores between UHC and non-incumbents.

2025 Plan Year Rate Cards for Recommended Blue Shield of California MAPD PPO and Non-Medicare "Split Family" Plans

Background for 2025 MAPD PPO Plan Rate Cards

For Non-Medicare dependents of retirees enrolled in the MAPD plan, as well as Non-Medicare retirees and dependents where at least one family member is Medicare eligible and enrolled in the MAPD plan, the plan administrator for Non-Medicare "split family" lives will follow the administrator of the MAPD plan in 2025. The 2025 rate card elements for Non-Medicare "split family" life plans were approved at the May 9, 2024, HSB meeting.

With today's recommendation, Non-Medicare family covered lives of a retiree where at least one family member is enrolled in the MAPD plan would have the following plan choices in 2025:

- BSC Access+ HMO;
- BSC Trio HMO; and
- BSC Non-Medicare PPO plan (and Choice Not Available PPO plan for those living outside of HMO service areas—see Appendix for information on Choice Not Available determination).

Background for 2025 MAPD PPO Plan Rate Cards

When setting the total MAPD plan premiums in the recommended 2025 MAPD plan monthly rate card, the following SFHSS costs are included:

- VSP Basic Plan vision premiums (2025 vision rates remain at 2024 levels); and
- The SFHSS Healthcare Sustainability Fund charge of $4.00 per retiree per month, which is $1 higher than the 2024 fee.

The MAPD plan rate card has distinct mixed Medicare family columns for each of these variations of non-Medicare dependent plan enrollment:

- BSC Access+ HMO;
- BSC Trio HMO; and
- BSC Non-Medicare PPO (and City Plan—Choice Not Available).

As in prior years, Mixed Medicare family enrollment will not be available in the 2025 plan year for the non-Medicare Health Net CanopyCare plan.

Retiree Medical Contributions in Rate Cards

The rate cards presented in this document reflect the full employer contributions for retiree medical coverage presently available to:

- Retired employees eligible for health benefits hired on or before January 9, 2009;
- Retired persons who retired for disability; and
- Surviving spouses or surviving domestic partners of active employees who died in the line of duty.

Retiree medical coverage — but no employer contribution — is available to retired employees hired on or after January 10, 2009, with at least 5 but less than 10 years of Credited Services with the Employers, and their surviving spouses or surviving domestic partners.

Retiree Medical Contributions in Rate Cards

Retiree medical coverage at the 50% employer Charter-contribution rate is available to retired employees hired on or after January 10, 2009, with greater than 10 years but less than 15 years of Credited Service with the Employers.

- This segment of retirees will receive 50% of the full employer Charter contribution for each retiree medical plan and coverage tier as reflected in the following rate card.

Retiree medical coverage at the 75% employer Charter-contribution rate is available to retired employees hired on or after January 10, 2009, with greater than 15 years but less than 20 years of Credited Service with the Employers.

- This segment of retirees will receive 75% of the full employer Charter contribution for each retiree medical plan and coverage tier as reflected in the following rate card.

2025 MAPD Plan Monthly Rate Card—Blue Shield of CA

C.N.A. = Choice Not Available	All Members in Medicare			Full Family — 2 in Medicare, 1+ Non-Medicare		
	Retiree Only	**Retiree + 1**	**Retiree + 2+**	**1+ Non-Medicare in BSC PPO/C.N.A.**	**1+ Non-Medicare in BSC Access+**	**1+ Non-Medicare in BSC Trio**
Premium	$534.37	$1,068.74	$1,603.11	$1,781.32	$2,028.04	$1,883.44
Vision	$4.15	$8.32	$11.76	$11.76	$11.76	$11.76
Expense[1]	$4.00	$4.00	$4.00	$4.00	$4.00	$4.00
Total	**$542.52**	**$1,081.06**	**$1,618.87**	**$1,797.08**	**$2,043.80**	**$1,899.20**
10-County Amount (or single tier premium, if less)[2]	$542.52	$0.00	$0.00	$0.00	$0.00	$0.00
Single Retiree Offset[3]	$0.00	$542.52	$542.52	$542.52	$542.52	$542.52
"Actuarial Difference"[4]	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Prop. E Contribution[5]	$0.00	$269.27	$269.27	$269.27	$269.27	$269.27
Subtotal City Contributions	$542.52	$811.79	$811.79	$811.79	$811.79	$811.79
Non-Bargained Contribution Rate 2025	**$0.00**	**$269.27**	**$807.08**	**$985.29**	**$1,232.01**	**$1,087.41**
Final Member Contribution 2025	**$0.00**	**$269.27**	**$807.08**	**$985.29**	**$1,232.01**	**$1,087.41**
Final Member Contribution 2024	**$0.00**	**$259.24**	**$776.99**	**$966.49**	**$1,145.16**	**$991.03**
Difference — 2025 vs. 2024 Contribution	**$0.00**	**$10.03**	**$30.09**	**$18.80**	**$86.85**	**$96.38**

NOTE: Footnotes 1-5 defined in the Appendix

MAPD Plan Monthly Rates and Contributions, 2024-2025

PY = Plan Year **C.N.A. = Choice Not Available**		**All Members in Medicare**			**Full Family — 2 in Medicare, 1+ Non-Medicare**		
		Retiree Only	**Retiree + 1**	**Retiree + 2+**	**1+ Non-Medicare in BSC PPO/C.N.A.**	**1+ Non-Medicare in BSC Access+**	**1+ Non-Medicare in BSC Trio**
Monthly Retiree Contributions	**PY 2024 (UHC)**	**$0.00**	**$259.24**	**$776.99**	**$966.49**	**$1,145.16**	**$991.03**
	PY 2025 (BSC)	**$0.00**	**$269.27**	**$807.08**	**$985.29**	**$1,232.01**	**$1,087.41**
	$ Change	*$0.00*	*$10.03*	*$30.09*	*$18.80*	*$86.85*	*$96.38*
	% Change	*--*	*3.9%*	*3.9%*	*1.9%*	*7.6%*	*9.7%*
Monthly Employer Contributions	**PY 2024 (UHC)**	**$521.46**	**$780.70**	**$780.70**	**$780.70**	**$780.70**	**$780.70**
	PY 2025 (BSC)	**$542.52**	**$811.79**	**$811.79**	**$811.79**	**$811.79**	**$811.79**
	$ Change	*$21.06*	*$31.09*	*$31.09*	*$31.09*	*$31.09*	*$31.09*
	% Change	*4.0%*	*4.0%*	*4.0%*	*4.0%*	*4.0%*	*4.0%*
Monthly Total Rate	**PY 2024 (UHC)**	**$521.46**	**$1,039.94**	**$1,557.69**	**$1,747.19**	**$1,925.86**	**$1,771.73**
	PY 2025 (BSC)	**$542.52**	**$1,081.06**	**$1,618.87**	**$1,797.08**	**$2,043.80**	**$1,899.20**
	$ Change	*$21.06*	*$41.12*	*$61.18*	*$49.89*	*$117.94*	*$127.47*
	% Change	*4.0%*	*4.0%*	*3.9%*	*2.9%*	*6.1%*	*7.2%*

Implementation and Member Outreach Strategy

Implementation

- Collaborate with BSC to develop a Joint Transition Plan.
  - Routine Areas for Group Medical Plan Carrier Change:
    - Continuity of Care
    - Pharmacy Transition Fills
- Initiate contracting process (benefit and Group set-up, plan documents, data sharing agreements).
- Finance/ESA (billing, payment, reconciliation procedures, EDI).
- Leverage HSS staff experience with vendor transition support:
  - Non-Medicare PPO for PY2022
  - Split-family HMO transition for PY2023

Member Outreach – Three-Phase Strategy

Jun – Aug: Planning

- HSS/BSC to Develop Web Resources/ Microsite Page
- HSS/BSC Train Member Services Staff
- BSC Supports Members Confirm Continuity of Provider Availability
- BSC Develops Continuity of Care Plan

Aug – Sep: Pre-seed & Drive Awareness

- HSS/BSC Develop Communication Collateral - Postcards, Emails, OE Letters and Guides
- HSS Member Services Take Pre-OE Calls and Directs Concerned Members to Developed Resources
- HSS Staff to Connect with RECCSF/POB to Develop Customized Outreach to their Memberships

Oct – Jan: Education & Support for OE and Beyond

- HSS/BSC to Host Special Webinars
- BSC Offer Special Office Hours to Transitioning Members
- HSS/BSC Provide Customized Instructions in Confirmation Letters and Welcome Packets.
- Extend Member Support through 2025

Staff Recommendation to the Health Service Board (HSB): Medicare Advantage Prescription Drug (MAPD) PPO RFP

Recommendation for the Health Service Board (HSB)

Approve, effective January 1, 2025:

Add the Blue Shield of California (BSC) Medicare Advantage Prescription Drug (MAPD) PPO plan for Medicare Members, and offer non-Medicare UnitedHealthcare Members the existing BSC HMO (Access+/Trio) and PPO plans—with the 2025 plan year rate cards contained in this material; and

Discontinue the UnitedHealthcare (UHC) MAPD PPO plan, UHC non-Medicare Select EPO plan, UHC non-Medicare Doctors EPO plan, and UHC non-Medicare PPO plan.

Health Service Board Discussion

Appendix

Appendix
Aon Consulting Subject Expert Credentials

Aon Consulting: Retiree Health Care Consulting Leader

Maridale Goff
Senior Vice President,
Retiree Healthcare
Sub Practice Leader

Responsibilities
Maridale is a Senior Vice President within our Health Solutions Practice. In this role she leads the Retiree Health Care Sub Practice, formulates and develops Aon's point of view on retiree health care opportunities and challenges for plan sponsors. Her work includes educating clients and collaborating with partners to deliver solutions that meet the needs of plan sponsors and their retirees.

Experience
Maridale has over two decades of experience in healthcare. She has worked to help plan sponsors design, operationalize and implement healthcare strategies across several populations and technical platforms. This includes traditional benefit administration platforms as well as exchange platforms that support group and individual strategies.

Education and Advocacy
Maridale graduated with honors from the University of Florida with a Bachelor of Science in Decision and Information Sciences. She is passionate about mental health issues and is a former board member of Hillside Hospital which serves children to young adults (6-24) with mental health issues.

Appendix
Plan History and Enrollment Summary

History of HSS Medicare Advantage Plans (2015-present)
Presented November 9, 2023

- UHC Self-insured City Plan with PDP changed to Fully Insured MAPD effective January 1, 2016.
  - All existing plan Members were migrated to the fully insured MAPD plans effective January 1, 2016, unless the Member changed to a different Medicare plan during OE.

- BSC 65+ (MAPD) discontinued, effective December 31, 2016.
  - Members were transferred to the UHC MAPD PPO Plan (the "New City Plan NPPO") effective January 1, 2017, unless Members elected the Kaiser MAPD during OE.
  - BSC and HSS enacted custom coding for eligibility to allow for "split-families". Split-family plan administration fully transitioned to the MAPD carrier after December 31, 2022.

Enrollment Summary

2024 Medicare-Eligible Members

	Retirees	Dependents	Total
UHC Medicare Part D Rx	14,141	3,780	**17,921**

Split Families

2024 Pre-Medicare-Eligible Members

	Retirees	Dependents	Total
UHC	167	857	**1,024**

- There are 17,921 Medicare-eligibles enrolled in a medical PPO supported by United.
- There are 9,304 Pre-Medicare-eligibles enrolled across four commercial medical plans. However, what is in scope for this RFP is the split families listed above. These family members will move to the pre-65 commercial plan of the winning carrier.
- Kaiser is not in scope for this RFP. HSS did ask for fully-insured premium pricing and experience transitioning Kaiser members as part of the MAPD RFP to understand the opportunity in future years.
  - Retirees can opt out of Kaiser and join the MAPD PPO plan.

Appendix
Claims Based Disruption –
Medical Provider Utilization Analysis

Medical Provider Disruption Scoring

	Total Claims	Total Contracted	Total Not Contract with History of Accepting (75%)	75 Calculation %	Total	Total %	Points Total
UHC Ancillary	214,209	213,047	1,162	872	**213,919**	99.86%	
UHC Provider	583,819	551,346	32,473	24,355	**575,701**	98.61%	
UHC Facility	231,570	210,644	20,926	15,695	**226,339**	97.74%	
UHC Total	**1,029,598**	**975,037**	**54,561**	**40,921**	**1,015,958**	**98.68%**	**5**
BSC Ancillary	214,209	198,722	0	0	**198,722**	92.77%	
BSC Provider	583,819	435,534	0	0	**435,534**	74.60%	
BSC Facility	231,570	201,243	0	0	**201,243**	86.90%	
BSC Total	**1,029,598**	**835,499**	**0**	**0**	**835,499**	**81.15%**	**3**
Anthem Ancillary	214,209	191,317	21,108	15,831	**207,148**	96.70%	
Anthem Provider	583,819	493,693	63,383	47,537	**541,230**	92.71%	
Anthem Facility	231,570	170,606	54,489	40,867	**211,473**	91.32%	
Anthem Total	**1,029,598**	**855,616**	**138,980**	**104,235**	**959,851**	**93.23%**	**5**

At the time of bidding, BSC did not have ability to differentiate between NCH and NCNH, therefore all providers that are not CP, are counted as NCNH

Appendix
Claims Based Disruption –
Prescription Drug Formulary Disruption

Prescription Drug Formulary Disruption (UHC/BSC)

- **Analysis of current 2024 UHC formulary relative to MAPD carrier formulary recommendations (Carrier formularies represent Open Medicare Part D formularies)**

Results Summary: 2023 UHC Formulary vs. 2024 MAPD Formularies

	RXs	%	Drugs	%	RXs	%	Drugs	%
No Change	787,558	99.89%	10,051	99.79%	765,868	97.14%	9,255	91.89%
Positive - Downtier	0	0.00%	0	0.00%	5,204	0.66%	105	1.04%
Negative - Uptier	0	0.00%	0	0.00%	17,001	2.16%	662	6.57%
Excluded	847	0.11%	21	0.21%	332	0.04%	50	0.50%
Total Positive or Neutral	**787,558**	**99.89%**	**10,051**	**99.79%**	**771,072**	**97.80%**	**9,360**	**92.93%**
Total Negative	**847**	**0.11%**	**21**	**0.21%**	**17,333**	**2.20%**	**712**	**7.07%**
Grand Total	**788,405**	**100.00%**	**10,072**	**100.00%**	**788,405**	**100.00%**	**10,072**	**100.00%**
No Change	787,558	99.89%	10,051	99.79%	765,868	97.14%	9,255	91.89%

- Formulary Disruption Ranking based on impacted products: 1) UHC 2) Blue Shield of California 4) Anthem
- Analysis assumes adoption of the following formularies: UHC Select Formulary, Anthem Formulary E4, Blue Shield of California EGWP 4-tier
- Analysis excludes vaccines
- Current Tier 4 copay ($20) is assumed to be equal to Tier 2 for purpose of positive/negative disruption

Prescription Drug Disruption Scoring

	Scripts Total	Negative Disruption	Percentage	1% results in deduction	Total	Full Total
UHC Tier Changes	**791,404**	0	0.00%	0.33	**0.00**	
UHC Tier Changes (HIV)	**791,404**	0	0.00%	0.67	**0.00**	
UHC Absolute (Not on Formulary)	**791,404**	847	0.11%	2.67	**0.29**	**11.71**
Blue Shield of California Tier Changes	**791,404**	17,001	2.15%	0.33	**0.72**	
Blue Shield of California Tier Changes (HIV)	**791,404**	727	0.09%	0.67	**0.06**	
Blue Shield of California Absolute (Not on Formulary)	**791,404**	332	0.04%	2.67	**0.11**	**11.11**
Anthem Tier Changes	**791,404**	12,994	1.64%	0.33	**0.55**	
Anthem Tier Changes (HIV)	**791,404**	251	0.03%	0.67	**0.02**	
Anthem Absolute (Not on Formulary)	**791,404**	14,578	1.84%	2.67	**4.91**	**6.52**

Prescription Drug Formulary Disruption

Top 10 Negatively Impacted Drugs Based on Prescription Count

UHC			
Rank	**Drug Name**	**Change**	**RXs**
1	Icosapent	Excluded or N/A	680
2	Budesonide-Formoterol	Excluded or N/A	89
3	Budesonide-Formoterol	Excluded or N/A	35
4	Fluticasone-Vilanterol	Excluded or N/A	18
5	Fluticasone	Excluded or N/A	19
6	Proair	Excluded or N/A	2
7	Fluticasone-Salmeterol	Excluded or N/A	2
8	Miebo	Excluded or N/A	1
9	APO-Varenicline	Excluded or N/A	1

Prescription Drug Formulary Disruption

Top 10 Negatively Impacted Drugs Based on Prescription Count

Blue Shield of California			
Rank	**Drug Name**	**Change**	**RXs**
1	Paxlovid	Negative - Down Tier 4→3	1,404
2	Symbicort	Negative - Up Tier 1→3	1,269
3	Cyclosporine	Negative - Up Tier 1→3	840
4	Mounjaro	Negative - Up Tier 2→3	795
5	Dexlansoprazole	Negative - Up Tier 1→3	678
6	Levemir	Negative - Up Tier 2→3	638
7	Spiriva	Negative - Up Tier 1→2	605
8	Vemlidy	Negative - Down Tier 4→3	550
9	Livalo	Negative - Up Tier 2→3	494
10	Rocklatan	Negative - Up Tier 2→3	444

Prescription Drug Formulary Disruption

Top 10 Negatively Impacted Drugs Based on Prescription Count

Anthem			
Rank	**Drug Name**	**Change**	**RXs**
1	Myrbetriq	Negative - Up Tier 2→3	2,300
2	Symbicort	Negative - Up Tier 1→2	1,269
3	Cyclosporine	Negative - Up Tier 1→2	840
4	Mounjaro	Negative - Up Tier 2→4	795
5	Sod	Negative - Up Tier 1→2	793
6	Brimonidine	Negative - Up Tier 1→2	785
7	Icosapent	Excluded or N/A	680
8	Dexlansoprazole	Negative - Up Tier 1→3	678
9	Spiriva	Negative - Up Tier 1→2	605
10	Brinzolamide	Negative - Up Tier 1→2	535

Appendix
Retail Pharmacy Network Disruption Analysis

Retail Pharmacy Network Access Analysis

- Percentage of 2024 pharmacies and prescriptions used by UHC from an In-Network Medicare Part D Retail Pharmacy

	UHC				Blue Shield of California				Anthem			
	RXs	%	Pharm.	%	RXs	%	Pharm.	%	RXs	%	Pharm.	%
No Change	639,832	100.00%	7,636	100.00%	638,272	99.76%	7,596	99.48%	639,623	99.97%	7,625	99.86%
Y→N	0	0.00%	0	0.00%	1,510	0.24%	36	0.47%	159	0.02%	7	0.09%
N→Y	0	0.00%	0	0.00%	50	0.01%	4	0.05%	50	0.01%	4	0.05%
Total Positive or Neutral	**639,832**	**100.00%**	**7,636**	**100.00%**	**638,322**	**99.76%**	**7,600**	**99.53%**	**639,673**	**99.98%**	**7,629**	**99.91%**
Total Negative	**0**	**0.00%**	**0**	**0.00%**	**1,510**	**0.24%**	**36**	**0.47%**	**159**	**0.02%**	**7**	**0.09%**
Grand Total	**639,832**	**100.00%**	**7,636**	**100.00%**	**639,832**	**100.00%**	**7,636**	**100.00%**	**639,832**	**100.00%**	**7,636**	**100.00%**

- Model assumes the incumbent's (UHC) 2024 Retail Network as the baseline.
- 433 pharmacies representing 13,052 prescriptions are from pharmacies that are now closed. Captured under "No Change"

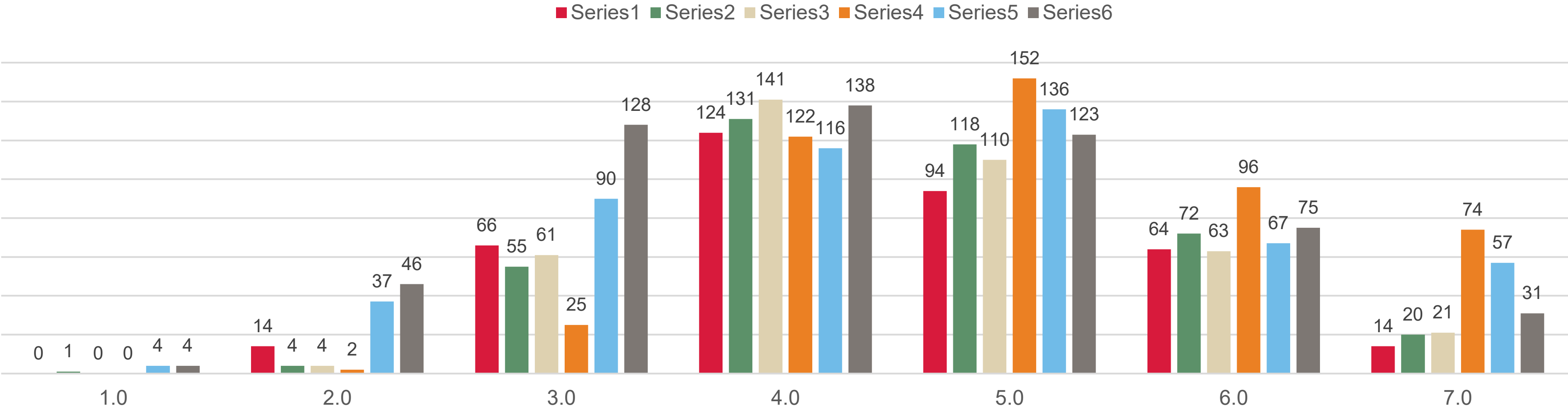
Appendix
Star Ratings Program and Scoring

Star Ratings Program

Category	Select Sample Measures	
Staying Healthy ▪ How often members received various screening tests, vaccines, and other check-ups	Breast Cancer Screening Colorectal Cancer Screening Cardiovascular Care—Cholesterol Screening Diabetes Care—Cholesterol Screening Glaucoma Testing	Annual Flu Vaccine Improving or Maintaining Physical Health Improving or Maintaining Mental Health Monitoring Physical Activity Adult BMI Assessment
Managing Chronic Conditions ▪ Frequency with which members received certain tests and treatments that help them manage their conditions	Medication Review Functional Status Assessment Pain Screening Osteoporosis Management in Women who had a Fracture Diabetes Care—Eye Exam Diabetes Care—Kidney Disease Monitoring	Diabetes Care—Blood Sugar Controlled Diabetes Care—Cholesterol Controlled Controlling Blood Pressure Rheumatoid Arthritis Management Improving Bladder Control Reducing the Risk of Falling Plan All-Cause Readmissions
Member Experience ▪ Includes ratings of member satisfaction with the plan	Getting Needed Care Getting Appointments and Care Quickly Customer Service	Overall Rating of Health Care Quality Overall Rating of Plan Care Coordination
Member Complaints and Appeals ▪ How often members filed a complaint against the plan	Complaints about the Health Plan Beneficiary Access / Performance Problems	Members Choosing to Leave the Plan Health Plan Quality Improvement
Customer Service ▪ How well the plan handles calls from members	Plan Makes Timely Decisions about Appeals Reviewing Appeals Decisions	Call Center Performance Enrollment Timeliness

Star Ratings Program

MA Contracts by Star Rating[1]



Data Source: 2023 CMS Star Rating Fact Sheet

[1] The COVID-19 pandemic presented significant challenges in providing care to Medicare-eligible patients resulting in meaningful reductions for certain measurement categories including breast cancer screenings, diabetes care, and general care for older adults. CMS implemented measure-level disaster adjustments **resulting in significant rating bumps for plans**

Star Ratings Scoring

Star Ratings		Criteria	UHC H2001	Blue Shield H4937	Anthem H4036
Contract	**2**	Full Award - 4 stars or higher 4 out of 5 years or better. 50% Award - 4 stars or higher 3 out of 5 years.	Full Award 4.5 and higher all 5 years	No Award 3.5 for 2 years.	Full Award 4.0 and higher all 5 years
Contract Score			**2**	**0**	**2**
Percentage of group members	**1**	80% of members in 4 or higher star plans full points Less than 80% to 70% of members in 4 or higher star plans 25% reduction Less than 70% to 60% of members in 4 or higher star plans 75% reduction Less than 60% to 50% of members in 4 or higher star plans 100% reduction Less than 50%, no points	Full Award 100% of group members	No Award 0%	Full Award 94.3%
Group Score			**1**	**0**	**1**
Percentage of group and individual members	**2**	80% of members in 4 or higher star plans full points Less than 80% to 70% of members in 4 or higher star plans 25% reduction Less than 70% to 60% of members in 4 or higher star plans 75% reduction Less than 60% to 50% of members in 4 or higher star plans 100% reduction Less than 50%, no points	25% Reduction 79%	No Award 0%	75% Reduction 67%
Group and Individual Score			**1.5**	**0**	**0.5**
Total			**4.5**	**0**	**3.5**

Appendix
Performance Guarantees

Performance Guarantees

- The RFP had two (2) sets of Performance Guarantees (PGs).
  - New PGs: HSS market-leading PGs, designed to promote partnership and collaboration between HSS, providers and payors.
    - All carriers asks to propose fees-at-risk for each (no current baseline).
    - New and market leading, therefore expected to be a stretch for all carriers.
    - Asked carriers to increase contracted providers, focusing on PCPs and mental health professions, and resolve access escalations related to key providers regardless of contract status (CP/NCH/NCNH).
    - Asked carriers to provide visibility into status of non-contracted providers.
  - Standard Operational PGs – baseline set to current PGs in place with the incumbent: requested 2.0% of fees-at-risk.

Total	UHC	BSC	Anthem
New (Market-leading) PGs (out of 4)	3.56	0.27	1.06
Operational PGs (out of 5)	5.0	0.5	2.75

Performance Guarantees (cont.)

- New (market-leading) PGs:
  - Incumbent response reflected current experience with SFHSS and Medicare population and aligned with baseline.
  - Non-incumbents provided less clarity as to metrics and/or amount of fees-at-risk.

- Operational PGs:
  - Incumbent baseline metrics already in place (met, as expected).
  - Non-incumbents proposed reduced overall fees-at-risk/thresholds or reduced fees-at-risk for specific metric or reduced thresholds/baselines for specific metrics.

Appendix
Rate Card Background Information

2024 MAPD Plan Monthly Rate Card—UHC

C.N.A. = Choice Not Available	All Members in Medicare			Full Family — 2 in Medicare, 1+ Non-Medicare		
	Retiree Only	Retiree + 1	Retiree + 2+	1+ Non-Medicare in UHC PPO/C.N.A.	1+ Non-Medicare in UHC Select EPO	1+ Non-Medicare in UHC Doctors EPO
Premium	$514.31	$1,028.62	$1,542.93	$1,732.43	$1,911.10	$1,756.97
Vision	$4.15	$8.32	$11.76	$11.76	$11.76	$11.76
Expense[1]	$3.00	$3.00	$3.00	$3.00	$3.00	$3.00
Total	**$521.46**	**$1,039.94**	**$1,557.69**	**$1,747.19**	**$1,925.86**	**$1,771.73**
10-County Amount (or single tier premium, if less)[2]	$521.46	$0.00	$0.00	$0.00	$0.00	$0.00
Single Retiree Offset[3]	$0.00	$521.46	$521.46	$521.46	$521.46	$521.46
"Actuarial Difference"[4]	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Prop. E Contribution[5]	$0.00	$259.24	$259.24	$259.24	$259.24	$259.24
Subtotal City Contributions	$521.46	$780.70	$780.70	$780.70	$780.70	$780.70
Non-Bargained Contribution Rate 2024	**$0.00**	**$259.24**	**$776.99**	**$966.49**	**$1,145.16**	**$991.03**
Final Member Contribution 2024	**$0.00**	**$259.24**	**$776.99**	**$966.49**	**$1,145.16**	**$991.03**
Final Member Contribution 2023	**$0.00**	**$225.69**	**$676.35**	**$921.14**	**$999.96**	**$937.19**
Difference — 2024 vs. 2023 Contribution	**$0.00**	**$33.55**	**$100.64**	**$45.35**	**$145.20**	**$53.84**

NOTE: Footnotes 1-5 defined on the next slide in the Appendix

MAPD Plan Rate Card Footnotes

1) **Expense:** HSS Healthcare Sustainability Fund charge of $4.00 per employee or retiree per month (increased by $1 for 2025 plan year).

2) **10-County Amount:** Amount derived from annual survey described in Charter Section A8.423 of contributions provided by 10 most populous counties in CA, not including San Francisco — called the “average contribution”. The 2025 10-County amount is $882.05.

3) **Single Retiree Offset:** Under Charter Section A8.428(b)(2), the 10-County amount is the first of three Charter contribution elements used to calculate retiree rates. Employers are required to pay lesser of the 10-County amount or actual cost of coverage for each retiree Member.

4) **"Actuarial Difference":** Under Charter Section A8.428(b)(3), the employers contribute the difference between Active Employee-Only premium and Early Retiree-Only premium. This is the second of three Charter contribution elements applied to the calculation of retiree rates.

5) **2000 Prop. E Contribution:** Under Charter Section A8.428(b)(3)(iii) and A8.428(c), employer contributions toward Retiree Only and Retiree +1 rates = 50% x [Total Rate Cost – 10-County Amount – “Actuarial Difference”]. This is the third of three Charter contribution elements that applied to the calculation of retiree rates.

Glossary of Plan Terms

Medicare Advantage Prescription Drug (MAPD) Plan: Medicare Advantage Prescription Drug Plan (MAPD) includes Medicare Part D and is available to beneficiaries enrolled in Medicare Part A and Part B. HSS offers only MAPD plans in which the Center for Medicare and Medicaid Services (CMS) pays a Managed Care Organization a per-member-per-month premium. HSS negotiates additional benefits not covered by MAPD plans alone

PPO: Preferred Provider Organization (PPO) benefit coverage is distinguished by a panel of preferred providers who contract with a health care vendor allowing the vendor to provider their services at a richer level of coverage. Non-preferred providers are covered at a much lower level thus the Member is required to pay a much higher level of the cost

Non-Medicare PPO Plan Choice Not Available (C.N.A.): Criteria for Availability and Rate Determination

Non-Medicare participants are assigned to the **Non-Medicare PPO Plan — Choice Not Available** as a plan they enroll in when they live in a zip code where the following occurs:

- Non-Medicare PPO Plan is the only plan choice available;
- Non-Medicare PPO Plan and Kaiser Permanente are available plan choices, but not BSC Access+ / UHC Select EPO; or
- Non-Medicare PPO Plan and BSC Access+ / UHC Select EPO are available plan choices, but not Kaiser Permanente.

Non-Medicare PPO Plan — Choice Not Available provides Member contribution relief primarily to active employees in the Hetch Hetchy/Moccasin areas, and early retirees living outside of the Bay Area of Northern California.