San Francisco Health Service System
Health Service Board

Medicare Plan Market Update

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Health Solutions

Empower Results®

Medicare Plan Market Update

Background for Today's Discussion

- Presently, Medicare-eligible retirees of the San Francisco Health Service System (SFHSS) are offered two plans through SFHSS, with employer contributions determined by City Charter formulas:
  - A National Medicare Advantage (MA) PPO plan through UnitedHealthcare (UHC); and
  - A Local MA HMO plan through Kaiser in California ("Kaiser Permanente Senior Advantage", or KPSA), Washington, Northwest, and Hawaii.

Medicare Plan Market Update

Purpose for Today's Discussion

- Today's discussion starts SFHSS and Health Service Board (HSB) planning as it pertains to potential engagement in a Request for Proposal (RFP) to the Medicare health plan market for the 2023 plan year.
  - How has the Medicare health plan marketplace evolved since SFHSS last altered its plan offerings in the 2017 plan year?
  - What national and California public sector employer trends can inform SFHSS and HSB thinking on future Medicare health plan offerings?
  - What steps can SFHSS and the HSB take over the next 6 to 8 months to decide the best course of action regarding Medicare plan offerings into the 2023 plan year?
    - **How do we assess how MA plans are meeting the needs of members and are there any significant gaps that we should explore solutions**

Contents—Medicare Plan Market Update

Medicare Plans Alignment with SFHSS Strategic Goals

SFHSS Strategy Considerations—Medicare Plans

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.

- **SFHSS Medicare plans should acknowledging Member costs (both through contributions and plan design) as well as the financial sustainability of the overall program.**

Reduce Complexity and Fragmentation

We believe in moving toward an integrated delivery system, focusing on primary care and prevention, and targeting and personalizing care.

- **SFHSS Medicare plans should reduce complexity and fragmentation by selecting vendor partners who focus on efficiency and quality by providing comprehensive and integrated health 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.

- **SFHSS Medicare plans should work with vendor partner(s) who will promote health literacy and provide Member advocacy care coordination and addresses racial equity and other negative Social Determinants of Health (SDoH).**

SFHSS Strategy Considerations—Medicare Plans

Choice and Flexibility

We believe in offering a range of designs, costs and services and collaborating with our stakeholder organizations, agencies, and departments to deliver health care services from the whole person perspective.

- **SFHSS Medicare plans should appreciating the various needs of Members and provide meaningful opportunity in the areas of health plan, plan design, and network/health systems.**

Whole Person Health and Well-being

We believe an organization that values supports members and their families' lives holistically and that fosters an environment and culture of well-being will have a happier, healthier, and more engaged population.

- **SFHSS Medicare plans should be provided by vendor partners who will support SFHSS' ongoing health and well-being activities and look to shift from sick care to health care and reduce barriers to care (e.g., negative SDoH).**

Current Medicare Health Plan Market

Current Medicare Health Plan Market

Available Plan Types—Medical Coverage[1]

Medicare Plan Type —>	Original Medicare	Medical Supplement	Medical Coordination of Benefits (COB)	Medicare Advantage[2]
Common Name	Part A (hospital) and Part B (medical)	Medigap[2]	COB	MA or Part C
Coverage Description	Basic Medicare with deductibles, copayments, and coinsurance	Additional coverage that **partially** "fills in" elements of Original Medicare cost sharing (varies by plan)	Additional coverage that **fully** "fills in" elements of Original Medicare cost sharing	Managed plan that provides coverage for medical and prescription drug services usually with member fixed dollar copayments for services
Funding Sources	Part A earned with 40 quarters of employment; Part B requires member premium (except low-income retirees)	Part A and B enrollment required, plus additional Supplement plan premium	Part A and B enrollment required, plus additional COB plan premium	MA plan becomes the member's Medicare coverage—lower premium (can be as low as $0) if member eligible for Parts A and B, higher premium if enrolled in Part B only
Member Cost	Part B premium	Part B premium, plan premium increases as benefit “fill-ins” increase	Part B premium, highest plan premiums given full “fill in” benefits	**Individual market plans** tend to have lower premiums, higher design cost share (copays) **Group plans** tend to have higher premiums, lower design cost share (copays)

1 See Appendix for background on federal Medicare program coverages (Parts A, B, C, and D)

2 Medicare Advantage plans, as well as older Medigap plans offered prior to introduction of Part D prescription drug plans in 2006, also provide prescription drug coverage (see next page)

Current Medicare Health Plan Market

Available Plan Types—Medical Coverage (continued)[1]

Medicare Plan Type —>	Original Medicare	Medical Supplement	Medical Coordination of Benefits (COB)	Medicare Advantage (MA)[2]
Common Name	Part A (hospital) and Part B (medical)	Medigap[2]	COB	MA or Part C
Additional Potential Member Benefits	None	Potentially, for additional premium (e.g., dental, vision, hearing)	Potentially, for additional premium (e.g., dental, vision, hearing)	Some plans include added member benefits such as dental, vision, hearing, meal delivery, and transportation
Quality Measures	None	None	None	CMS Star Ratings (see pages 23-24)
Member Care Coordination	No	No	No	Yes

1 See Appendix for background on federal Medicare program coverages (Parts A, B, C, and D)

2 Medicare Advantage plans, as well as older Medigap plans offered prior to introduction of Part D prescription drug plans in 2006, also provide prescription drug coverage (see next page)

Current Medicare Health Plan Market

Available Plan Types—Prescription Coverage[1]

Medicare Plan Type —>	Medicare Part D	Prescription Drug Plan (PDP)	Medicare Advantage (MA)[2]
Common Name	Part D (introduced as part of Medicare Modernization Act of 2003)	PDP	MA or Part C
Coverage Description	Four-level coverage with deductible, then coinsurance, then “doughnut hole”, then catastrophic coverage	Higher level of benefits than base Part D plan design—typically includes some level of “doughnut hole” fill-in	Managed plan that provides coverage for medical and prescription drug services usually with member fixed dollar copayments for services
Funding Sources	Premium paid by plan member	Premium paid by member (higher premium than base Part D plan); typically purchased by those also purchasing Medicare Supplement / COB plans for medical coverage	MA plan becomes the member's Medicare coverage -- lower premium (as low as $0 in some cases) if member eligible for Parts A and B, higher premium if enrolled in Part B only
Member Cost	Standard Part D plans have lowest premiums among PDPs	Premiums increase as plan benefits increase	See page 7—premium is integrated for medical and drug
Additional Potential Member Benefits	None	None	Some plans include added member benefits such as dental, vision, meal delivery, and transportation
Quality Measures	CMS Star Ratings (see pages 23-24)	CMS Star Ratings (see pages 23-24)	CMS Star Ratings (see pages 23-24)
Member Care Coordination	No	No	Yes

1 See Appendix for background on federal Medicare program coverages (Parts A, B, C, and D)

2 Medicare Advantage plans also provide medical coverage (see prior page)

U.S. Population Distribution in Medicare Plans

- There are close to 70 million Medicare eligible individuals in the United States—most qualify by age (65 or older), some qualify by disabled status
- Of all Medicare eligible individuals in 2020:
  - About **two-thirds** are enrolled in Original Medicare
    - A portion of those in Original Medicare (15 million) also purchase individual Medigap plans to supplement Original Medicare hospital/medical benefits
    - A portion of those in Original Medicare (21 million) also purchase a Part D Prescription Drug Plan (PDP) to have pharmacy benefit coverage
  - About **one-third** are enrolled in Medicare Advantage plans
    - About 19 million are in individual marketplace MA plans
    - About 5 million are in group-sponsored MA plans (such as employer-sponsored plans like SFHSS)
    - MA plans can be HMO-based (with in-network benefits only) or PPO-based (with in-network and out-of-network benefits), and can be local/regional or national
- Per Kaiser Family Foundation (KFF) in a 2019 report, about 40% of Medicare eligible individuals in California enroll in an MA plan

Employer Medicare Plan Strategy—Two Approaches

Health Care Reform

- Medicare and Retiree Drug Subsidy (RDS) program changes
- Benefit design requirements and coverage mandates
- Health insurance exchanges

Universal Employer Objectives

- Support overarching business and Human Resources strategies
- Manage cost, risk, and ongoing program management burden
- Simplify administration

Confluence of new challenges, new opportunities, and common plan sponsor objectives are reshaping the retiree health care market into two primary benefit sourcing strategies

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Strategic Themes in Medicare Plan Market

Benefits That Go Beyond Original Medicare (Parts A and B)

Strategy	Medicare Plan Approaches
Group-Based (Direct Sponsorship by Employer)	▪ Medicare Supplement / Coordination of Benefits Medical Plans with Medicare Part D Prescription Drug Plans ▪ Medicare Advantage Regional / Local Plans (PPO and HMO) ▪ Medicare Advantage National Plans (PPO and HMO)
Individual Market-Based	▪ Private exchange-based strategies supported by employer account funding via Health Reimbursement Account mechanism

Key Market Issues / Challenges / Opportunities

- Evolution of Medicare plans post-2020 federal elections
- Outlook for federal government funding for Medicare plans from Centers for Medicare and Medicaid (CMS)
- Medicare Access and CHIP Reauthorization Act (MACRA) and broader U.S. social welfare program reforms
- Long-term outlook for the group Medicare Advantage PPO strategy

Why Employers Offer Medicare Advantage (MA) Plans

- "Original Medicare" is an unmanaged indemnity plan characterized by a high degree of inefficiency
  - High emergency room usage
  - High hospital admission (and re-admission) rates
  - High costs for "end-of-life" support
  - Poor care coordination among primary care, institutional care, and pharmacy
- Medicare supplement plans (for instance, "Medigap") are generally inefficient
  - They coordinate after the "Original Medicare" program—but do not provide effective care management to support retirees or manage costs
- Thus, employer-sponsored MA plans (first allowed by 1997 legislation) have steadily increased in prevalence
  - MA plans provide an intensive **quality** focus not present in other Medicare plan types
  - MA plans facilitate cost optimization while allowing for added member benefits beyond those in other Medicare plan types (such as non-emergent medical transportation and post-discharge meal delivery benefits)

How Original Medicare Compares to Medicare Advantage

	"Original Medicare"	Medicare Advantage
Costs	▪ Member charged deductibles for Parts A and B costs, including monthly Part B premium. ▪ Member responsible for 20% Part B coinsurance for Medicare-covered services through participating providers and after meeting the Part B deductible.	▪ Cost-sharing varies depending on plan. ▪ Usually there is a copayment for in-network care, and coinsurance for out-of-network care (PPO models). ▪ Plans may charge a monthly premium in addition to Part B premium.
Supplemental Insurance	▪ Choice to pay an additional premium for Medigap to cover Medicare cost-sharing.	▪ Cannot enroll in a Medigap plan.
Provider Access	▪ Can see any provider that accepts Medicare (non-participating providers must collect directly from patient).	▪ HMO models typically only in-network providers. ▪ PPO models can use any provider that accepts Medicare.
Referrals	▪ Do not need referrals for specialists.	▪ HMO models typically require referrals for specialists. ▪ PPO models typically require any referred specialists to be in-network.
Drug Coverage	▪ Must sign up for a stand-alone prescription drug plan.	▪ In most cases, plan provides prescription drug coverage (higher premium may be required).
Other Benefits	▪ Does not cover routine vision, hearing, or dental services.	▪ May cover additional services such as vision, hearing, and/or dental (these may increase your premium and/or other out-of-pocket costs).
Out-of-Pocket Limit	▪ No out-of-pocket limit.	▪ Annual out-of-pocket limit. ▪ Plan pays full cost of your care after you reach the limit.
Quality Measures	▪ None	▪ Star Ratings—CMS measurement of up to 45 quality unique quality and performance measures.

Source: *Medicare Rights Center: www.medicareinteractive.org*

Medicare Plan Offering Prevalence—Key California Counties

Bay Area County Offerings to Medicare Retirees

- **All sponsor at least one MA plan**—directly, or through an individual plan marketplace ("Exchange")
- Most provide an employer contribution for retiree's coverage but not for dependents
- Additional coverage and contribution details are in the Appendix to this presentation

County	Group MA Plan(s)	Other Group Plan(s)	Marketplace Platform
Alameda*	Kaiser Permanente Senior Advantage (KPSA)	N/A	Private Exchange (via Benefits)
Contra Costa*	KPSA and Health Net (for retirees receiving County Sponsored plans)	Health Net and Contra Costa Health Plan COB HMO / PPO (for retirees receiving County Sponsored plans)	CalPERS (for retirees receiving coverage through CalPERS)
Marin	KPSA and UnitedHealthcare (UHC) MAPD	N/A	N/A
Napa	N/A	N/A	CalPERS
San Francisco	KPSA and UHC MAPD	N/A	N/A
San Mateo	KPSA, UHC MAPD, Blue Shield of CA (new in 2021)	BSC COB (eliminated after 2020)	N/A
Santa Clara*	N/A	N/A	CalPERS
Solano	N/A	N/A	CalPERS
Sonoma	KPSA	Anthem/CVS EPO and PPO (coordinate with Medicare)	AARP Medigap and AARP PDP plans

** County is in annual SFHSS "10-County Survey"*

Medicare Plan Offering Prevalence—Key California Counties

Other 10-County Survey County Offerings to Medicare Retirees

- **All sponsor at least one MA plan directly**
- Those providing an employer contribution do so for retiree's coverage (not dependents)
- Additional coverage and contribution details are in the Appendix to this presentation

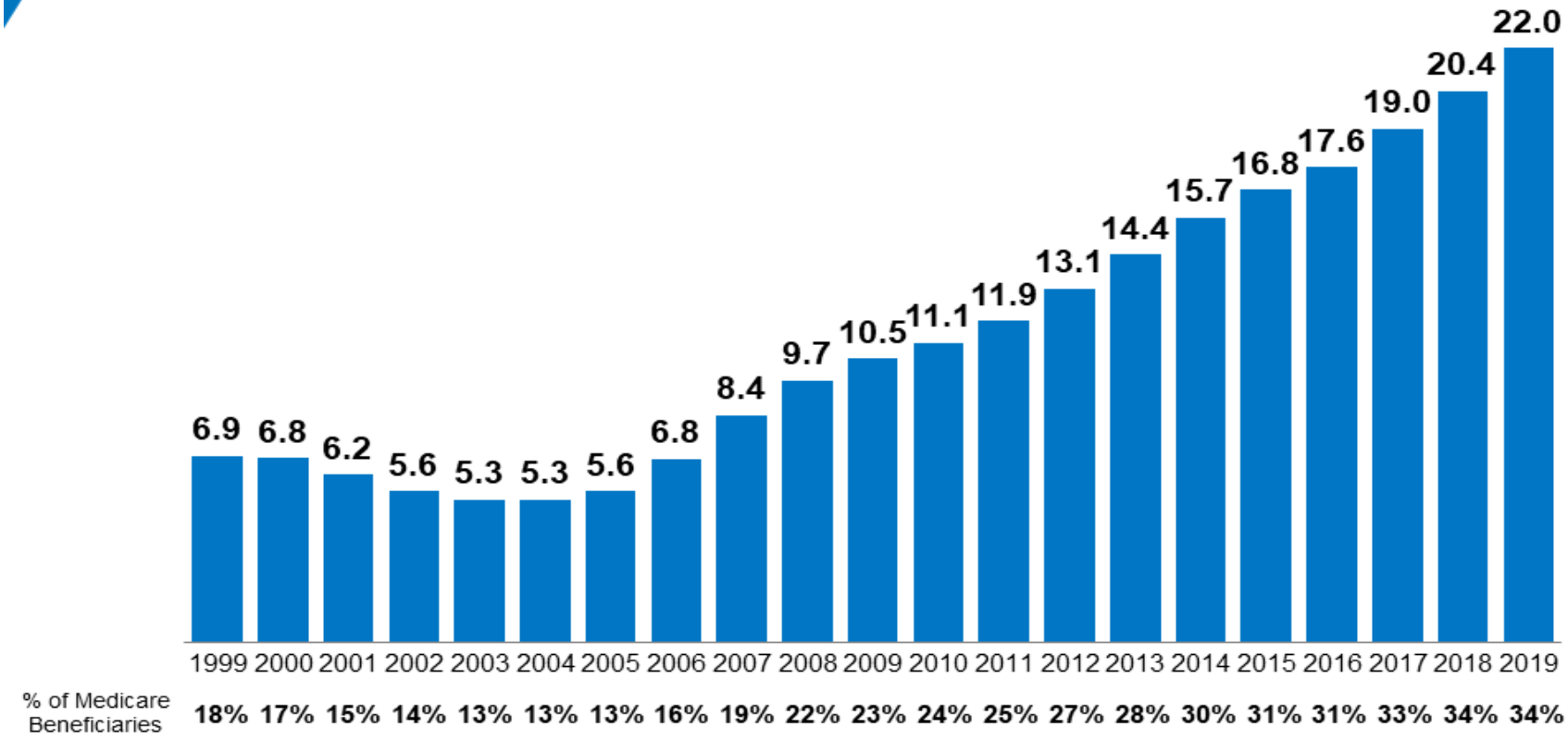
County	Group MA Plan(s)	Other Group Plan(s)	Marketplace Platform
Fresno	KPSA	United American COB with UHC Rx	N/A
Los Angeles	KPSA, UHC MAPD, SCAN (Southern California MA plan)	Anthem BCBS Medicare Supplement	N/A
Orange	KPSA, Anthem BCBS, SCAN	BSC PPO, Anthem BCBS HMO and PPO	N/A
Riverside	KPSA, UHC MAPD, SCAN (for retirees receiving County-sponsored plans)	ExclusiveCare supplement / COB plans (all retirees—local network plan), UHC EPO / PPO COB (for retirees receiving County-sponsored plans)	CalPERS (for retirees receiving coverage through CalPERS)
Sacramento	KPSA and UHC MAPD	N/A	N/A
San Bernardino	KPSA and BSC	BSC COB	N/A
San Diego	KPSA, UHC MAPD, Health Net	Health Net HMO, UHC supplement	N/A

Medicare Advantage Market Update

Medicare Advantage Plan Enrollment Continues to Climb

Figure 1

Total Medicare Advantage Enrollment, 1999-2019
(in millions)

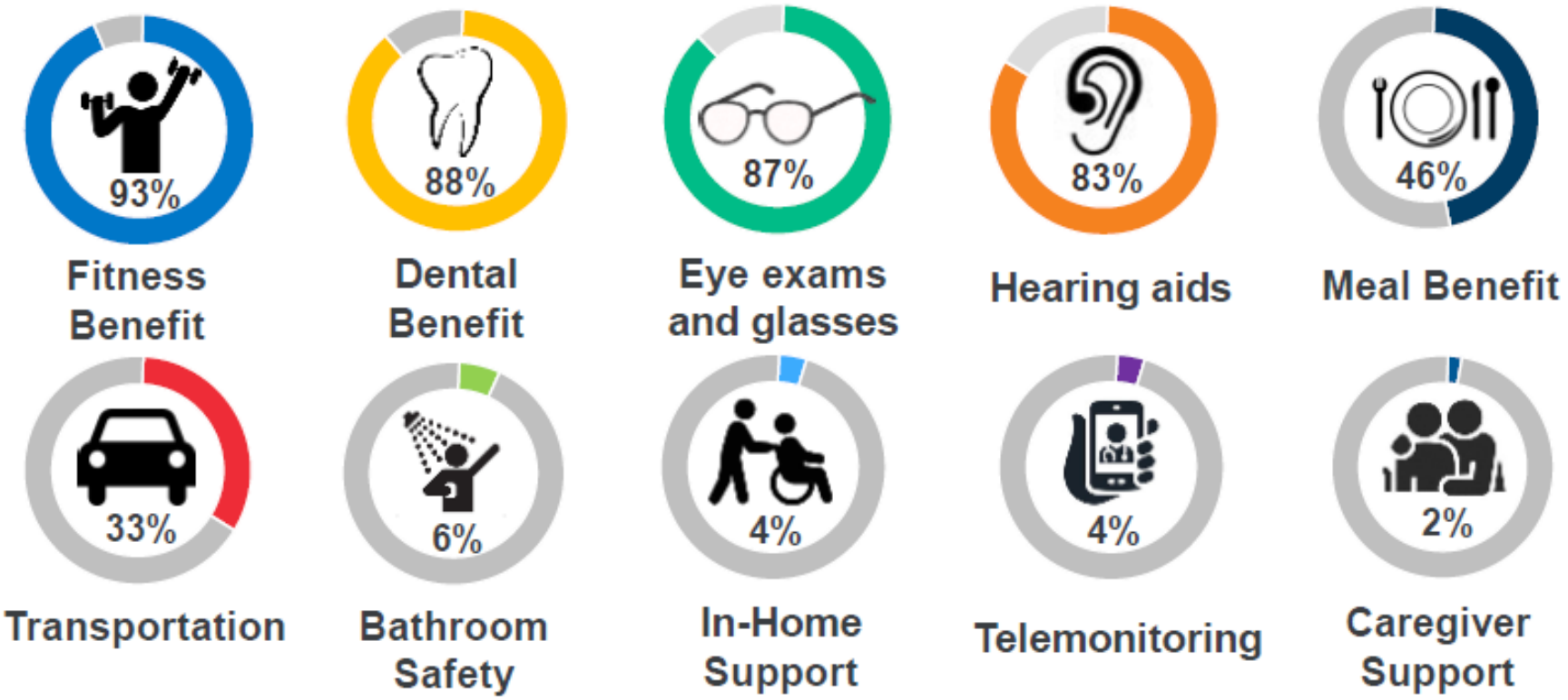


NOTE: Includes cost plans as well as Medicare Advantage plans. About 64 million people are enrolled in Medicare in 2019.
SOURCE: Kaiser Family Foundation analysis of CMS Medicare Advantage Enrollment Files, 2008-2019, and MPR, 1999-2007; enrollment numbers from March of the respective year, with the exception of 2006, which is from April.

Medicare Advantage Plan Features

- Most Medicare Advantage plans provide fitness, dental, vision, and hearing benefits—with other benefits such as meal delivery and transportation continuing to emerge

Percentage of Medicare Advantage Plans in 2020 Offering "Additional Benefits"



NOTE: Dental includes plans that only provide preventive benefits, such as cleanings. Excludes SNPs, EGHPs, HCPPs, and PACE plans.
SOURCE: Kaiser Family Foundation analysis of CMS's Landscape files for 2020.

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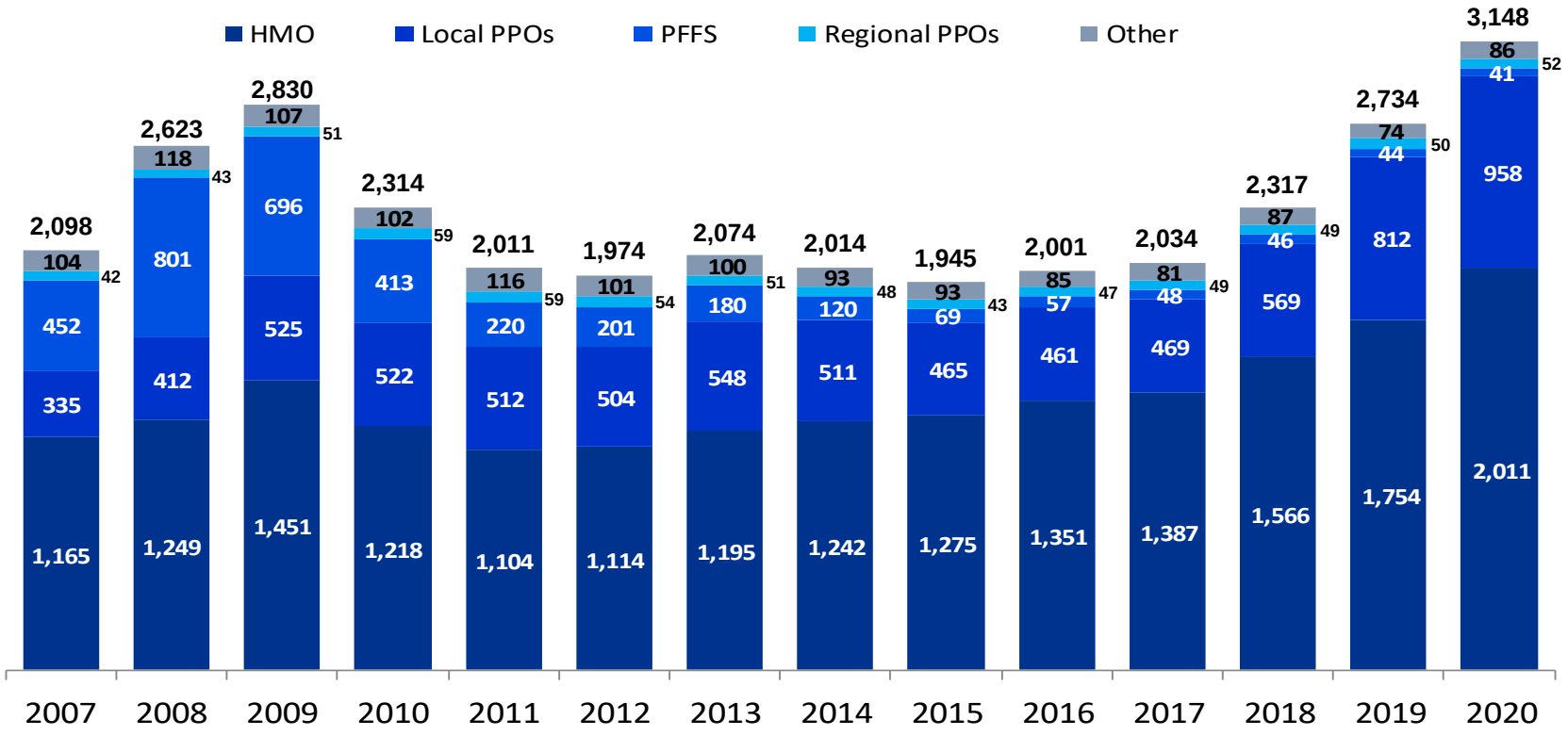
Medicare Advantage Plan Landscape

- The **number of unique plans increased significantly for 2020**, and the market is very robust

Distribution of Medicare Advantage Plans By Plan Type, 2007-2020



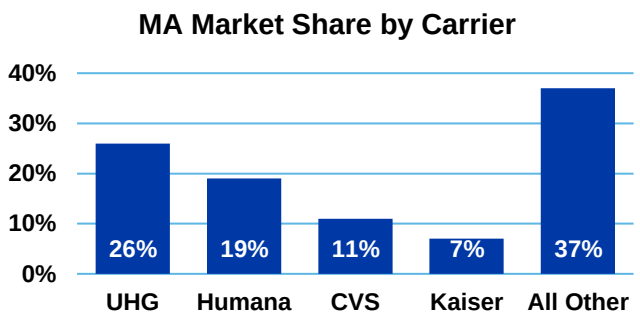
NOTE: Excludes SNPs, EGHPs, HCPPs, and PACE plans. Other category includes cost plans and Medicare MSAs.
SOURCE: Kaiser Family Foundation analysis of CMS's Landscape Files for 2007-2020.

Medicare Advantage Plan Landscape

- **United and Humana** support approximately 45% of the entire Medicare Advantage market
- **United** is the largest in the group space, with Kaiser Permanente at fourth-largest

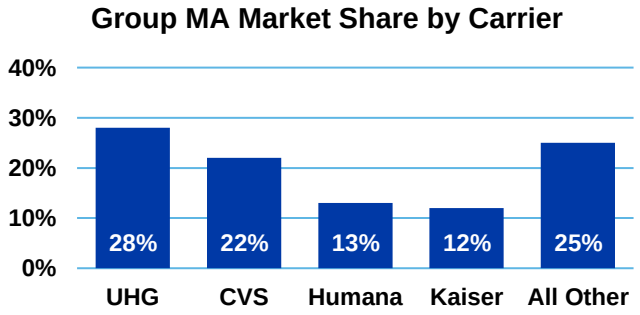
Carriers with Largest MA Membership (1/2020)

Rank	Carrier	2020 Enrollment	2020 Market Share
1	UnitedHealth Group, Inc.	6,217,258	26.3%
2	Humana Inc.	4,375,981	18.5%
3	CVS Health Corporation	2,486,702	10.5%
4	Kaiser Foundation Health Plan, Inc.	1,657,518	7.0%
5	Anthem Inc.	1,277,945	5.4%
6	Blue Cross Blue Shield of Michigan	586,481	2.5%
7	WellCare Health Plans, Inc.	569,684	2.4%
8	CIGNA	484,439	2.0%
9	InnovaCare Inc.	261,558	1.1%
10	Centene Corporation	245,493	1.0%
	Subtotal >250,000	**18,163,059**	**77%**
	All Other	5,481,583	23%
	Total	**23,644,642**	**100%**



Carriers with Largest Group-Based MA Membership (1/2020)

Rank	Carrier	2020 Enrollment	2020 Market Share
1	UnitedHealth Group, Inc.	1,325,733	28.4%
2	CVS Health Corporation	1,036,026	22.2%
3	Humana Inc.	601,894	12.9%
4	Kaiser Foundation Health Plan, Inc.	551,869	11.8%
5	Blue Cross Blue Shield of Michigan	443,483	9.5%
6	Anthem Inc.	167,609	3.6%
	Subtotal >100,000	**3,959,005**	**85%**
	All Other	705,082	15%
	Total	**4,664,087**	**100%**



SOURCE: Centers for Medicare and Medicaid Services January 2020 enrollment files

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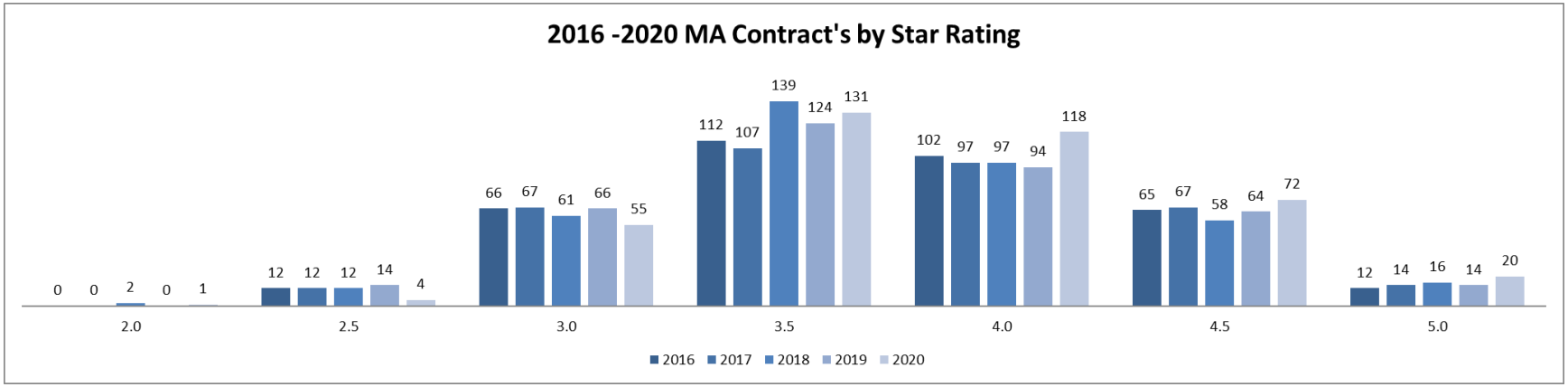
MA Plan Quality Measures—Star Ratings

- CMS Star Ratings impact the amount of Federal Government bonus funding that an MA plan receives—and the higher the funding, the lower the plan's premium to employers/individual members
- Medicare scores how well MA plans perform in up to 45 **quality-based** categories, culminating in a rating from one star (worst) to five stars (best)—quality performance categories scored include:
  - Staying healthy—screenings, tests, and vaccines
  - Managing chronic (long-term) conditions
  - Plan responsiveness and care
  - Member complaints, problems getting services, and choosing to leave the plan
  - Health plan customer service
- Star Ratings are also determined by CMS for Part D prescription drug plans—up to 14 measures for stand-alone PDPs

MA Plan Quality Measures—Star Ratings

2020 MA Plan Star Rating Distribution (Impacts 2021 Federal Subsidies to Plans)

- The Medicare Advantage market is making a concerted effort to improve Star Ratings
- **Over 600 Medicare Advantage (Excluding PDP) contracts** were filed for 2020
- **401 contracts were rated**; new plans and plans lacking sufficient data were excluded
  - 2020 nationwide Star Rating weighted average across all MA contracts is **4.17**
    - **79.1% of the beneficiaries are enrolled in a 4.0+ Star plan**
  - 20 contracts received a 5-Star Rating for 2020—**Including the KPSA plan offered by SFHSS**
  - **The UHC MAPD plan offered by SFHSS has a 4.5-Star Rating, among the highest for a national PPO plan**



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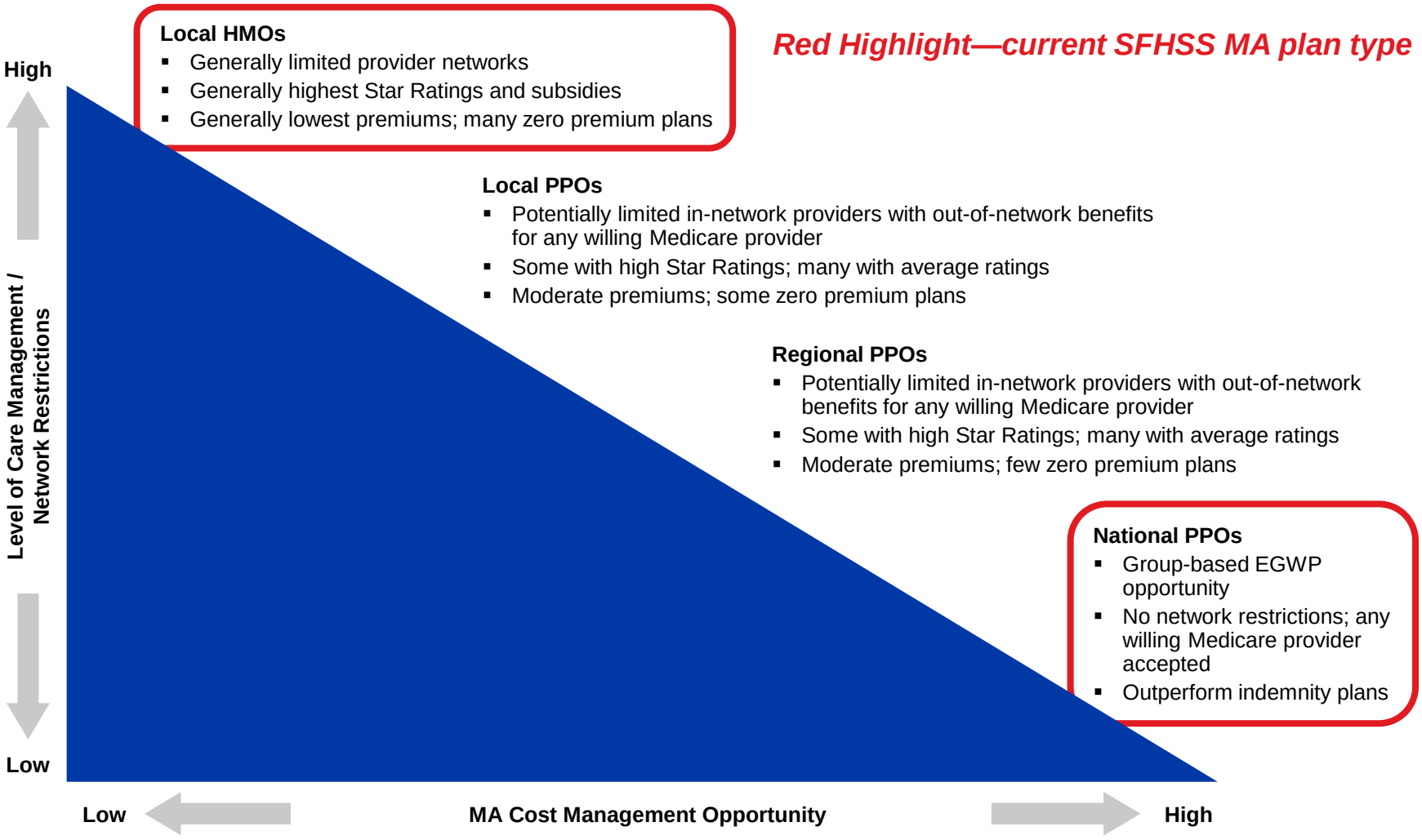
Medicare Advantage Plan Types



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National Group-Based MA PPO Plans

Sources of Savings Relative to Traditional Program

- Programs are structured to reduce cost and improve the quality of care

Source	Theme	Comments
1) Optimizing Reimbursement	Federal Subsidies	▪ Overall nationally and across all products, Medicare Advantage plans are subsidized on par with traditional Medicare plans ▪ Plans invest these subsidies in efficient care delivery and member/provider outreach strategies to manage care, align incentives, reduce cost, and drive value
	Risk Adjustment	▪ Federal subsidies are modified based on actual member health status to support payment equity among plans, which creates an incentive to serve all beneficiaries and accurately capture and report actual health claims data under the plan
	Star Program Bonuses	▪ Plans with strong CMS quality ratings receive bonuses/additional reimbursements from Medicare, which creates an incentive toward quality care, and generates additional savings opportunities for plans that qualify
2) Building Provider Relationships	Provider Collaboration	▪ Strategic arrangements between the plan and key providers are common ▪ Include performance incentives to drive appropriate retiree utilization and capture complete/accurate encounter data that supports risk adjustment opportunity
3) Improving Member Health	Care Management	• Offer enhanced preventive benefits relative to Medicare • Provide a coordinated, integrated approach to care and benefits – Aims to reduce ER visits, hospital admissions, and lengths of stay • Offer enhanced case management for complex medical needs

Plan sponsors committed to a group-based Medicare retiree benefits strategy should consider a Medicare Advantage PPO approach; recent carrier MA PPO competitive bids have resulted in 20%- 50% savings in medical plan costs relative to current without plan design changes

COVID-19 Impacts on MA Plans

COVID-19 Impacts on MA Plans

Key Themes Impacting 2021 Medicare Advantage Premiums and Designs

- 2021 CMS revenue to MA plans came in slightly below expectations (unrelated to COVID)
- Health Insurer Tax (HIT) elimination relieves material financial pressure on 2021 premiums
- Direct impact of COVID-19 equates to an increase in costs due to testing and hospitalizations
- Indirect impact of COVID-19 has resulted in a reduction in claims due to deferral/elimination of non-emergent care and reduced in-home nursing visits funded by the MA plan
  - This could create financial windfalls for MA plans in 2020, which they may share with plan sponsors and retirees into 2021 (this occurred with the UHC MA PPO plan for SFHSS)
- The expectation is that 2021 MA risk scores and CMS revenue will be artificially depressed since 2021 scores are based on 2020 claims, which are artificially low due to deferral of non-emergency care
  - Many expect that this will drive down CMS revenue to MA plans for 2021
  - Expected to be a one-year issue, but unclear at this point

The overall impact of these themes on 2021 MA premiums and designs is a function of specific group and plan facts and circumstances

Next Steps in SFHSS Medicare Plans
Future Evaluation

Next Steps in SFHSS Medicare Plans Future Evaluation

Considerations Into 2023 Plan Year for SFHSS Medicare Plan Offerings

- Today's discussion initiates evaluation of pathways SFHSS could take for Medicare plan offerings for the 2023 plan year.
- Goals for today's review were:
  - Review perspectives on alignment of SFHSS Strategic Goals to Medicare plan offerings;
  - Enhance HSB Commissioner knowledge on types of Medicare plans and general U.S. population distribution among types of Medicare plans;
  - Discuss general Medicare plan offering strategies by employers;
  - Provide information on Medicare plans offered by key California counties (10-County Survey counties in California, plus other Bay Area counties not in 10-County group);
  - Engage in deeper review of the Medicare Advantage plan market including CMS Star Ratings; and
  - Inform on expected COVID-19 related pandemic impacts to Medicare Advantage plans.

Next Steps in SFHSS Medicare Plans Future Evaluation

Considerations Into 2023 Plan Year for SFHSS Medicare Plan Offerings

- Today's discussion will guide consideration in coming months as to whether to consider changes to SFHSS Medicare plan offerings for the 2023 plan year, including a possible RFP to the Medicare plan market.
- We appreciate your questions and comments today—knowing your input as HSB Commissioners will help guide SFHSS in this evaluation process in coming months.

Appendix—Medicare Program Overview

Appendix—Medicare Program Overview

Medicare is a federally administered health insurance program that was signed into law in 1965—Medicare covers three population segments:

- Those age 65 and older;
- Those under age 65 with certain disabilities; and
- Those of any age with End-Stage Renal Disease (permanent kidney failure requiring dialysis or kidney transplant)

"Original Medicare" consist of two parts:

- **Part A, Hospital Insurance**—Automatic enrollment (generally), funded through Medicare payroll taxes on employers and employees
- **Part B, Medical Insurance**—Voluntary enrollment that requires a Part B premium from participants (premium covers about 25% of program costs; remaining 75% is funded through general tax revenue)

Appendix—Medicare Program Overview

Subsequent developments in Medicare programs to address "Original Medicare" shortcomings:

- **Part C, Medicare Advantage Program:**
  - Administered by Medicare-approved private insurance companies with a variety of available plans (e.g., HMO, PPO, fee-for-service, etc.)
  - Must provide Medicare Parts A and B benefits at minimum, but typically provide more prescription drugs and other benefits
  - Voluntary enrollment which requires a Part B premium, and may require an additional premium
  - Medicare contributes funding to these private insurance plans directly through an annual bid process to support Medicare A and B benefits

Appendix—Medicare Program Overview

Subsequent developments in Medicare programs to address "Original Medicare" shortcomings (continued):

- **Part D, Prescription Drug Coverage:**
  - Introduced by the Medicare Prescription Drug Improvement and Modernization Act of 2003
  - Administered by Medicare-approved private insurance companies
  - Must provide at least the minimum level of Medicare Part D benefits, with some plans providing additional prescription drug benefits
  - Voluntary enrollment which requires a Part D premium, and may require an additional premium
  - Premium targeted to cover 25.5% of program costs; 74.5% funded through general tax revenue
  - Medicare contributes funding to these private plans directly through an annual bid process to support Medicare D benefits

Appendix—Medicare Program Overview

- Popular Medicare plans beyond "Original Medicare"

Health Care Options	Description
Medicare Advantage (Part C)	▪ Privatized Medicare benefits which **replace** Traditional Medicare ▪ HMO, POS, PPO, PFFS, Special Needs Plans ▪ Approximately **19 million** Medicare beneficiaries receive coverage through the 2020 individual Medicare Advantage market, representing approximately **30%** of total Medicare enrollment ▪ **Approximately 93% of Medicare beneficiaries have access to at least one zero premium Medicare Advantage Part D Plan in 2020**
Medigap	▪ Private indemnity plans which **supplement** Traditional Medicare ▪ Ten standard, federally and state regulated plans generally available nationally ▪ Approximately **15 million** Medicare beneficiaries have 2020 individual Medigap coverage, representing approximately **24%** of total Medicare enrollment
Medicare Part D Prescription Drug Plans (PDPs)	▪ Medicare Part D prescription drug benefits **delivered** through private plans ▪ CMS establishes minimum benefit requirements and each carrier determines their own design and formulary and files annually with CMS for approval ▪ Standard or enhanced coverages – Typically use 5-tier cost sharing – Plan designs, retail networks, formularies, clinical programs can vary ▪ Approximately **21 million** Medicare beneficiaries have 2020 individual Part D coverage

Appendix—Key California County Medicare Plan Offering Details

Bay Area County Landscape—Medicare Plan Offerings

- Each Bay Area counties offers at least one MA plan to their Medicare retirees, with some offering other plan choices and platforms including CalPERS

County	Medicare Health Plans Offered	Employer Contribution Approach	Website With Information
Alameda*	Group MA (KPSA), individual marketplace plans (through Via Benefits)	Those with 10+ years of service receive a Monthly Medical Allowance to apply towards cost of KPSA or a Via Benefits plan—amount varies by years of service (full MMA at 20+ years of service—$443.28 per month in 2020—amount same whether covering only self, or self plus dependents	https://www.acera.org/sites/main/files/file-attachments/2020-oe-guidebook.pdf
Contra Costa*	County-sponsored: 9 plans offered - MA, COB HMO, and COB PPO plans through Kaiser, Health Net, and Contra Costa Health Plan. Separately, six bargained groups have retiree medical coverage through CalPERS.	Varies by retiree group—8 rate sheets for retirees on County-sponsored plans, 6 rate sheets for retirees on CalPERS plans	https://www.contracosta.ca.gov/1343/Employee-Benefits
Marin	Group MA plans—Kaiser Low, Kaiser Silver, UHC MAPD	Varies by date of retirement and plan selected (longer service retirees generally have 100% employer contribution for RET Only coverage); no incremental employer contribution for dependents	https://www.mcera.org/retirees/health-benefits/county
Napa	Coverage offered through CalPERS	Information available by contacting Napa County Human Resources department	https://www.countyofnapa.org/Faq.aspx?QID=601
San Francisco	Group MA plans (UHC MAPD, KPSA in CA, Kaiser Medicare HMOs in WA/NW/HI)	Determined by City Charter formulas applied to plan premium rates (full contribution if hired on/before January 9, 2009); employer contributions are higher for self plus dependents versus self only	https://sfhss.org/sites/default/files/2020-05/6.%202020_RET_Guide_5.06.20_new_phone.pdf
San Mateo	Group plans: KPSA, UHC Secure Horizons MA HMO, BSC MA PPO (new in 2021—replaces former BSC COB plan)	Varies by represented group—generally ranges from $400/month to $700/month; no incremental employer contribution for dependents	https://hr.smcgov.org/sites/hr.smcgov.org/files/2020%20Retiree%20Guide%20FINAL_10.3.pdf
Santa Clara*	Coverage offered through CalPERS	Employer contribution for most retirees is the single tier premium for KPSA, with no added employer contribution for dependents (can vary for certain retiree groups)	https://www.sccgov.org/sites/esa/ebenefits/retirement/Pages/retiree-medical.aspx
Solano	Coverage offered through CalPERS	Your CalPERS retirement benefit is based on a formula that takes into account your age, years of service, and highest year(s) salary and the CalPERS formula for which you are qualified.	https://www.solanocounty.com/depts/hr/employeebenes/medretiree.asp
Sonoma	Group plans: KPSA (CA), Kaiser HMO (NW/HI), County EPO and PPO plans through Anthem BCBS / CVS Caremark; AARP Medigap plans also available	County contribution is generally available for those hired before January 1, 2009 (varies by MOU or Salary Resolution). Retirement Health Reimbursement Account (HRA) provided by County for those hired on/after January 1, 2009, based on MOU.	https://sonomacounty.ca.gov/HR/Benefits/Benefit-Directory-for-Retirees/

* Part of 10-County Survey

Other CA "10-County" Landscape—Medicare Plan Offerings

- Medicare Advantage plan offerings are also prominent among the remaining seven "10-County Survey" counties in California

County	Medicare Health Plans Offered	Employer Contribution Approach	Website With Information
Fresno	United American Medicare COB w/UHC Rx, KPSA High and Low plans (dental and vision plans packaged with medical)	Not specified on Fresno County website	https://www.co.fresno.ca.us/departments/human-resources/employee-benefits/health-plans/retiree-health-plan-information
Los Angeles	Anthem Medicare Supplement plan, 3 Medicare Advantage plans (KPSA, UHC HMO, SCAN)	The County subsidizes retiree medical/dental insurance based on the member's years of service credit; a minimum of ten years of service applies (40% @ 10 years plus 4% per year - to max 100% at 25 years). Retirees < 10 years service have coverage but no employer contribution.	https://www.lacera.com/healthcare/healthcare.html
Orange	Two PPO plans through BSC, two non-MA HMO plans through Anthem BCBS (for those enrolled in Part B only), three MA HMO plans (KPSA, Anthem BCBS, SCAN), two MA PPO plans (both through Anthem BCBS). Two BSC PPO plans and KPSA also available to Medicare retirees with Part B only.	Retiree medical grant based on age and service at retirement - max service credit at 25 years - grant reduces by 50% upon attainment of Medicare eligibility	https://www.ocgov.com/gov/hr/eb/overview/rmdip.asp
Riverside	CalPERS and Exclusive Care supplement/COB plans for all retirees except LIUNA and SEIU, who are offered County plans (Exclusive Care supplement/COB, KPSA High/Low plans, UHC EPO and PPO COB plans, UHC MA HMO plan, SCAN MA HMO plan)	County contribution varies by bargaining unit at time of retirement - $25 to $256 per month (no employer contribution for dependents)	https://benefits.rc-hr.com/RetireeBenefits.aspx
Sacramento	Four MA plans - 2 through UHC (HMO and PPO), 2 through KPSA (Silver and Gold)	No employer contribution in most cases	https://personnel.saccounty.net/Benefits/Pages/RetiredEmployee.aspx
San Bernardino	Four MA plans (BSC High/Low HMO, Kaiser High/Low HMO), BSC COB plan	No employer contribution	https://hr.sbcounty.gov/employee-benefits/retiree-medical-dental-plans/
San Diego	Three MA HMO plans (HealthNet, KPSA, UHC), one non-MA HMO plan (HealthNet), one UHC supplement plan	Certain retirees who have 10+ year of service receive a Health Insurance Allowance (HIA) to help pay for cost of retiree medical - monthly allowance amounts range from $200 to $400	https://health.sdcera.org/enrollment/enrollment/2021-open-enrollment.html

Appendix—Glossary of Terms

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- **COB:** Coordination of Benefits (type of Medicare Medical Supplement plan that fully fills in deductible, copayment, and coinsurance gaps in Original Medicare coverage)
- **CMS:** Centers for Medicare and Medicaid (a federal agency within the Department of Health and Human Services that oversees programs including Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and the state and federal health insurance marketplaces)
- **HIT:** Health Insurer Tax (a federal tax on insured health plans brought by the Affordable Care Act, but permanently eliminated after 2020 by federal legislative action in December 2019)
- **HMO:** Health Maintenance Organization (a health care plan with benefits available only when using network providers, except for emergency care)
- **KPSA:** Kaiser Permanente Senior Advantage (regional MA HMO plan offered by SFHSS in Northern California to Medicare retirees)
- **MA:** Medicare Advantage (a type of Medicare plan offering integrated medical and prescription drug benefits with substantial quality measurement guided by nationally recognized standards through CMS)

Appendix—Glossary of Terms (continued)

- **MACRA:** Medicare Access and CHIP [Children's Health Insurance Program] Reauthorization Act (federal legislation passed in 2015 that created the Quality Payment Program that repealed the Sustainable Growth Rate (PDF) formula, changed the way that Medicare rewards clinicians for value over volume, streamlines multiple quality programs under the new Merit Based Incentive Payments System (MIPS), and gives bonus payments for participation in eligible alternative payment models)
- **Medicare:** federal health care program started in 1965 that is offered to three types of Americans—those age 65 and older, those meeting specific disability criteria, and those with End Stage Renal Disease (ESRD)
- **Medigap:** series of federally-approved individual Medicare Medical Supplement plans (10 plans offered in most states including California)
- **Original Medicare:** term that captures Medicare medical benefit programs originally started by federal legislation in 1965—consisting of Hospital benefits ("Part A") and Medical benefits ("Part B")
- **PDP:** Prescription Drug Plan (plans enabled by Medicare Part D prescription drug benefit program started by federal legislation in 2006)

Appendix—Glossary of Terms (continued)

- **PPO:** Preferred Provider Organization (a health care plan with a higher level of benefits available for use of network providers, and lower level of benefits for non-network providers)
- **Supplement:** type of Medicare medical plan that partially fills in deductible, copayment, and coinsurance gaps in Original Medicare coverage
- **UHC MA PPO:** UnitedHealthcare Medicare Advantage Preferred Provider Organization (national MA PPO plan offered by SFHSS to Medicare retirees)