Request for Proposals (RFP) for Health Plans for the 2022 Plan Year Summary of Results and Recommendations

February 11, 2021

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- Future Objectives and Unrealized RFP Opportunities
  - Provider Gaps
  - Pathways to Addressing Provider Gaps

Recommendation for Health Plan Offerings

Recommendation for the Health Service Board

The SFHSS staff recommends that the Health Service Board (HSB):

1. Approve the addition of HealthNet Canopy HMO (flex funded) and Blue Shield of California (BSC) PPO with Accolade (self-funded) to the San Francisco Health Service System (SFHSS) plan offerings; continue with BSC Access+ and Trio plans for the PY2022; discontinue United Healthcare PPO.

Health Plan Offerings for Plan Year 2022

As a result of the Request for Proposals (RFP) for Health Plans for the 2022 Plan Year (the "RFP") the San Francisco Health Service System (SFHSS) recommends the following health plans for our SFHSS Members who are active employees, non-Medicare-eligible retirees, and their respective non-Medicare-eligible dependents (collectively, "Non-Medicare Members"):

- Blue Shield of California (BSC) Access+ HMO **(continuing)**
- BSC Trio HMO **(continuing)**
- Health Net Canopy Care (Canopy) HMO **(new)**
- BSC Blue Card Network (national) PPO with Accolade **(new)**
- Kaiser HMO (excluded from the RFP) (status quo)

Health Plan Offerings for Plan Year 2022 –
System Competition Model

Aon introduced the system competition model to the Health Service Board and the HSB adopted the model at the July 2019 meeting as part of a broader market assessment. From this model, the recommendation results in the following:

Health System Models—System Competition Scenario

	HMO				PPO (BSC)
What are my choices at annual enrollment?	Kaiser	HN Canopy	BSC Trio	BSC Access+	
Where can I seek care? *	Kaiser Providers	In-Network Providers in Canopy Care	In-Network Providers in Trio	In-Network Providers in Access+	In-Network and Out-of-Network for BSC Providers
Do I need a referral from my PCP to get care?	Yes	Yes—PCP selected from Canopy Care ACO partners	Yes—PCP selected from Trio ACO partners	Yes—PCP selected from Access+ ACO partners	No
How much do I pay when I seek care?	Office Visit: $20 Inpatient Hospital: $100 Generic Rx: $5	Office Visit: $25 Inpatient Hospital: $200 Generic Rx: $10			Office Visit: D+15% Inpatient Hospital: D+15% Generic Rx: $10 (D = deductible)
Who coordinates my care?	Your Kaiser Primary Care Provider (PCP)	Your PCP you identified through your selected ACO	Your PCP you identified through your selected ACO	Your PCP you identified through your selected ACO	You with support from Accolade

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

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Forecasted Savings from RFP

- $16M projected overall cost savings for three-year RFP period (2022-2024) through a combination of administrative fee reductions and shift in Rx rebate cost share percentage in SFHSS favor – $14M to employers and $2M to active employees/early retirees based on MOU/City Charter contribution sharing formulas
- Further cost savings anticipated with introduction of Health Net Canopy as members can now choose another focused HMO plan with deeper levels of provider risk sharing via capitation
- Nominal cost change for new PPO administrator, though potential exists to markedly improve member health and lower plan claims into the near term via improved utilization of health care services with the introduction of Accolade for member decision support and clinical advocacy

Forecasted Savings from RFP

The following table shows the anticipated savings based on incumbent plan quotations for each of the next three years as well as in aggregate ($M), based on existing plan headcount remaining constant over the next three years[1].

$ Million	PPO	Non-Kaiser HMO	Combined
Total Savings			
o 2022	$0.4	$4.7	$5.1
o 2023	$0.4	$5.0	$5.4
o 2024	$0.4	$5.4	$5.8
o Three-Year	$1.2	$15.1	$16.3
Employee/Early Retiree Savings			
o 2022	$0.1	$0.5	$0.6
o 2023	$0.1	$0.5	$0.6
o 2024	$0.1	$0.6	$0.7
o Three-Year	$0.3	$1.6	$1.9
Employer Savings			
o 2022	$0.3	$4.2	$4.5
o 2023	$0.3	$4.5	$4.8
o 2024	$0.3	$4.8	$5.1
o Three-Year	$0.9	$13.5	$14.4

[1]Savings based on comparison of current administrative fees trended 2% annually through 2024 to incumbent Respondent administrative fee quotations for 2022-2024, as well 6% annual trend in prescription drug rebate levels applied to difference between current and proposed pharmacy rebate sharing percentages.

Medicare Retirees

The recommended plans and the RFP have no effect on the current SFHSS Medicare-eligible Member population or their available plans (Kaiser Permanente Senior Advantage and UnitedHealthcare MAPD).

RFP Accomplishments and Objectives

RFP Accomplishments and Objectives

The objectives of the RFP were met as described below:

- Creates competition between carriers, plans and integrated delivery systems for Members and promotes value-based payment over fee-for-service models
- Partners with quality care focused organizations
- Improves Member choice among HMO plans with integrated delivery systems
- Secures a sustainable PPO plan options and improves support for SFHSS and enrolled Members
- Strengthens our existing HMO services, benefits and Member support
- Advances whole person health and wellbeing for Members
- Manages future risk and costs through innovation and transparency
- Ensures minimal Member disruption into the 2022 plan year

Panel Selection and Scoring Rubric

Panel Selection

- RFP Evaluated Respondents across 6 categories
  - Questionnaire
  - Financial
  - Non-Financial
  - Oral Interviews
  - Alignment with SFHSS and Member Needs
  - Disruption

- SFHSS carefully vetted, assembled and convened a panel of 6 experts
  - comprised of an equal number of internal SFHSS and external subject-matter experts
  - expertise included: cross-disciplinary health benefits, integrated delivery, behavioral health, diverse populations, health information technology, financial, rate-setting, clinical and operational experience
  - experts from Bay Area municipal health benefits administration agencies, and a former chief medical officer for the health insurance marketplace for the state of California

- Process Spanned: 3 months, 18 separate meetings, four interviews

- Panel
  - assessed and scored the responses to the RFP Questionnaire
  - calculated the disruption
  - reviewed relative financial strength for the three-plan year

Scoring Rubric

Category	Description	Points
Questionnaire	Strength and comprehensiveness of each responses to the RFP questionnaire, including standard questions for all Respondents, plan and network-specific questions, and pharmacy questions.	400
Financial	The relative strength of each financial proposal (rates, fees, discounts, rebates, sustainability) calculated by projected costs over PY2022 – PY2024 for each HMO proposal and each PPO proposal using current plan enrollments.	300
Non-Financial	SFHSS identified and described twelve (12) principal categories of work and 114 underlying scope of work elements, terms and conditions within Section 5.7 of the RFP. Respondents were evaluated based on their confirmation (or acceptance), modification (expansion or reduction), or rejection of each service level, benefit, and negotiable or non-negotiable requirement	250
Oral Interviews	The Evaluation Panel evaluated the strength of each Respondents' answers to three comprehensive questions at their oral interview, conducted between January 5th and January 7th.	250
Alignment with SFHSS and Member Needs	Alignment of each proposed plan with the SFHSS and Member needs described throughout the RFP, including, but not limited to, broad acceptance of SFHSS administrative requirements, degree to which Respondent would be an active, flexible and cooperative partner with SFHSS from annual renewals to day-to-day operations, lack of or proposed strategy for minimizing member disruption (outside of pharmacy and geographical access), addressing solutions for the SFHSS Member population respective to current plan-type preferences (e.g. understanding that a growing percentage of our population, currently at approximately 97%, prefers an HMO model and that a majority of that population prefers the Kaiser integrated system model).	200
Disruption	Relative degree of member, network, benefit, and pharmacy disruption (Rx - 50 points, benefit/geographical access - 50 points) for each proposed network compared to current SFHSS HMO and PPO plans.	100

Plans Selected and Plans Not Selected

Plans Selected and Retained: BSC Trio HMO

Plan Name	Key Elements	Score (out of 1500)
BSC Trio HMO	• Highest scoring plan fully funded and second highest flex-funded HMO plan • Integrated model which provides direct competition with Kaiser and Health Net Canopy Care (Canopy) • Cost savings without reductions to current Member services, administrative support, and benefits • Promotes value-based payment model through use of capitation and cost target methodology that includes ACO physician/facility partner risk sharing linked to financial goal and quality goal attainment • In-depth understanding and acceptance of required scope of work, and recognition of the ongoing need for comprehensive, high-value health benefits and services for SFHSS Members • Key strategic partnerships, expansion of benefits and access to benefits, and targeted whole person health and wellbeing • Acceptance of key operational, data, and administrative elements necessary for a cooperative and strategic partnership • Transparent approach, awareness of current issues, concrete plans for overcoming obstacles • Accepts SFHSS innovations, data sharing, collaboration, and increased transparency to manage future risk and claim costs • Lower administrative fees for PY2022 than PY2021, full pharmacy rebate passthrough for PY2022 • No member disruption for the approximately 12,000 members now enrolled in Trio, as well as an alternative option for approximately 16,000 Access+ members (or 70% of total Access+ members) now utilizing physicians in the Trio provider network	1270.71 (fully funded); 1250.71 (flex funded)

Plans Selected and Retained: BSC Access+ HMO

Plan Name	Key Elements	Score (out of 1500)
BSC Access+ HMO	• Second highest ranked HMO plan, highest flex-funded HMO plan; 83.9% of total • No disruption for PY2022 for Members currently enrolled • In-depth understanding and acceptance of required scope of work, and recognition of the ongoing need for comprehensive, high-value health benefits and services for SFHSS Members • Key strategic partnerships, expansion of benefits and access to benefits, and targeted whole person health and wellbeing • Acceptance of key operational, data, and administrative elements necessary for a cooperative and strategic partnership • Transparent approach, awareness of current issues, concrete plans for overcoming obstacles • Accepts SFHSS innovations, data sharing, collaboration, and increased transparency to manage future risk and claim costs • Lower administrative fees for PY2022 than PY2021, full pharmacy rebate passthrough for PY2022	1258.84 (flex funded); 1237.34 (fully funded)

Plans Selected and Retained: Health Net Canopy HMO

Plan Name	Key Elements	Score (out of 1500)
Health Net Canopy HMO	• Third highest ranked HMO plan (behind Trio and Access+); 82.3% of total • Favorable Financial score (254 out of 300) • Provides access to MarinHealth and Zuckerberg San Francisco General Hospital • Provides overlapping coverage and options for Members with at least twelve (12) major Bay Area provider groups covered in full or in part by BSC Trio • Integrated model • Promotes value-based payment model through significant use of capitation and other network provider-delivered medical services, as well as rigorous quality measurement • In-depth understanding and acceptance of required scope of work, and recognition of the ongoing need for comprehensive, high-value health benefits and services for SFHSS Members • Key strategic partnerships, expansion of benefits and access to benefits, and targeted whole person health and wellbeing • Acceptance of key operational, data, and administrative elements necessary for a cooperative and strategic partnership • Transparent approach, awareness of current issues, concrete plans for overcoming obstacles • Cost savings without reductions to current Member services, administrative support, or benefits • Innovations, data sharing, collaboration, and increased transparency to manage future risk and claim costs	1234.26 (flex funded)

Plans Selected and Retained: BSC Blue Card Network with Accolade PPO

Plan Name	Key Elements	Score (out of 1500)
BSC Blue Card Network with Accolade PPO	• Highest ranked PPO; 83.0% of total available points • Administration of same benefits as incumbent Respondent UnitedHealthcare • Addition of Accolade providing our highest cost and highest risk population with the highest levels of service, guidance and navigation, advocacy, and clinical care • Registered Nurse or Health Assistant to assist every PPO Member with specific events or answer any healthcare and benefits questions 24/7 • Increased collaboration and partnership with a carrier who oversees more than 3% of our overall Non-Medicare population • Projected optimized cost savings within our most high-cost population and increased ROI in Years 1 through 3 • Target our highest risk population with the highest levels of service, navigation, advocacy and clinical support.	1245.64 (self-funded)

Plans Not Selected: PPO

Only Blue Shield of California with Accolade PPO was selected because Members would not benefit from multiple PPO plans given in-network providers are nearly identical across carriers. Through the recommendation to have Blue Shield of California in partnership with Accolade administer and support the self-funded PPO plan, while maintaining and/or improving current service levels (such as providing every PPO member with access to dedicated clinical support and a trusted Health Assistant and Registered Nurse), SFHSS will:

- Increase collaboration and partnership with a carrier who oversees more than the 3% of our overall Non-Medicare population that is enrolled today in the PPO
- Optimize cost savings within our most high-cost population
- Target our highest risk population with the highest levels of service, navigation, advocacy, and clinical support

Plans Not Selected: HMO

The Anthem HMOs, the Health Net Standard HMO, and the UHC Doctors Plan were not selected as follows:

- They scored lower than the recommended plans
- The more developed partnership between Canopy and Health Net (the Canopy Care HMO) was selected over the less developed UHC Doctors Plan EPO partnership with Canopy
- The more integrated and provider-focused Canopy HMO was selected over Health Net's Standard HMO
- The Anthem HMOs did not capture the scope of work, terms, and requirements of the RFP, while BSC and Health Net accepted them almost entirely and expanded on several requirements

Future Objectives and Unrealized RFP Opportunities

Provider Gaps

While more integrated systems from Health Net (Canopy) and Blue Shield of California (Trio) provide additional choices and competition to the existing Kaiser HMO plan, the RFP failed to produce a standalone proposal from Sutter Health Plus.

- Sutter Health met the requirements to bid and met the required pre-proposal deadlines for their Notice of Intent to Bid and Conflict of Interest Disclosure Statement, Sutter Health Plus ultimately and formally withdrew from the RFP on October 20, 2020.

As a result, while Sutter physicians and facilities are prominent within the BSC Access+ Network, only a limited set of Sutter facilities are in-network for BSC Trio today, including:

- Five California Pacific Medical Center facilities in San Francisco, Alta Bates/Summit Medical Center campuses in Oakland/Berkeley, and Eden Medical Center in Castro Valley
- Palo Alto Medical Foundation (PAMF) physicians and Asian American Medical Group (AAMG) are not currently part of the Trio network

Provider Gaps continued

- Access+ stands out given the network contains most Bay Area provider groups/systems.
- Employees and Early Retirees living in the Hetch Hetchy/Tuolumne County area geography can currently select the UHC PPO plan.
    - Starting in 2022, the available plan will change to the BSC PPO with Accolade
    - SFHSS will work with HMO plan providers in coming months to explore potential to bring key health systems in Tuolumne County and surrounding area into HMO plan offerings, to potentially be able to expand service area availability of one or more SFHSS HMO plans into these communities

Pathway to Addressing Provider Gaps

To address the provider gaps as a result of Sutter Health Plus failure to submit a bid in response to the RFP, over the next year SFHSS recommends we:

- Follow the advice provided by Sutter Health in their RFP intent to bid withdrawal letter to explore future opportunities for partnering with respect to the Sutter clinicians
- Work with our partners at BSC to expand Provider Group options, including Sutter in particular, under the Trio HMO plan
- Report our progress to the Health Service Board at each public meeting
- Uncover Member reasons for choosing Access+ to determine best way to meet their needs during possible plan migration
- Commence targeted outreach in advance of Open Enrollment to educate members about the advantages of the available choices
- Collaborate with carriers to promote their plans
- Educate and train Benefit Analysts to guide members to the best plan for their situation

Recommendation for the Health Service Board

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