

Board Education

Types of Medicare Plans and Considerations for Future Plan Decisions

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Agenda

- Medicare Basics
- Original Medicare
- The Parts of Medicare
- Medicare Coverage Options
- Employer Group Coverage
- Considerations and Reference
- History of Health Service Board Medicare Plan Decisions
- Medicare Plan Decision Analysis
- Explanation of OPEB and Impact on Benefits
- Analysis of Changing Medicare Plans and Its Impact on SFHSS Members

Medicare Basics

What is Medicare?

Medicare is a federal health insurance program that provides health care coverage to millions of Americans. Administered by the Centers for Medicare & Medicaid Services (CMS), the federal agency that oversees Medicare. It was established in 1965 under Title XVIII of the Social Security Act.

Who is eligible?

U.S. citizens or permanent legal residents for at least 5 years who meet one of the following:

Age 65 or older represent ~90% of beneficiaries

Under age 65 and living with a disability

Have end-stage renal disease (ESRD), also called kidney disease

Have amyotrophic lateral sclerosis (ALS), also called Lou Gehrig's disease

A Medicare beneficiary is an individual officially enrolled in and covered by Medicare.

Original Medicare: Parts A and B



PART A Hospital insurance

- Inpatient hospital care and inpatient rehabilitation
- Skilled nursing facility care
- Hospice care
- Post-acute home health care



PART B Medical insurance

- Physician and outpatient hospital services
- Preventive services, screenings, and vaccines
- Durable medical equipment
- Lab and X-rays
- Dialysis

NOT Covered by Original Medicare

-  Most outpatient prescription drugs
-  Routine dental care and dentures
-  Routine eye exams and eyeglasses
-  Routine hearing exams and hearing aids

Value-added benefits like:

-  Gym memberships
-  Chiropractic and Acupuncture
-  Transportation
-  Post Discharge meals delivery service



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Outpatient prescription drug coverage is offered through Part D plans.

Value-added benefits (gym memberships or transportation) may be offered by Medicare Supplement and Medicare Advantage plans.

How Parts A and B are Funded



PART A Hospital insurance

Primarily financed through the 2.9% Medicare payroll tax, split between employers and workers (1.45% each).

Additional funding comes from taxes on Social Security benefits and interest on trust fund investments.

Beneficiaries are “entitled” to premium-free Part A if they worked and paid Medicare taxes for 10 years or 40 quarters.



PART B Medical insurance

Funded mainly by general federal revenues, which cover about three-quarters of program costs.

Monthly premiums paid by enrolled beneficiaries fund the remaining share.

Most beneficiaries in 2026 pay the standard monthly premium of \$202.90 to Social Security.

Source: Centers for Medicare & Medicaid Services, 2026 Medicare Parts A & B Premiums and Deductibles, November 14, 2025.

Original Medicare Beneficiary Premiums and Cost Sharing

Beneficiaries may pay a Part B premium, and Part A & B deductibles, coinsurance and copayments.

Part A — Hospital insurance	2026
Inpatient hospital deductible per benefit period, days 1-60	\$1,736
Daily hospital coinsurance, days 61–90	\$434
Daily coinsurance, lifetime reserve days after 90	\$868
Skilled nursing facility coinsurance from days 21–100	\$217

Part B — Medical insurance	2026
Standard monthly premium*	\$202.90
Annual deductible	\$283
Coinsurance for most services	20%
Annual out-of-pocket limit	None

* Income-related monthly adjustment amount (IRMAA), 2026

Beneficiaries with modified adjusted gross income at or below \$109,000 (individual) or \$218,000 (joint) pay the standard \$202.90 monthly Part B premium.

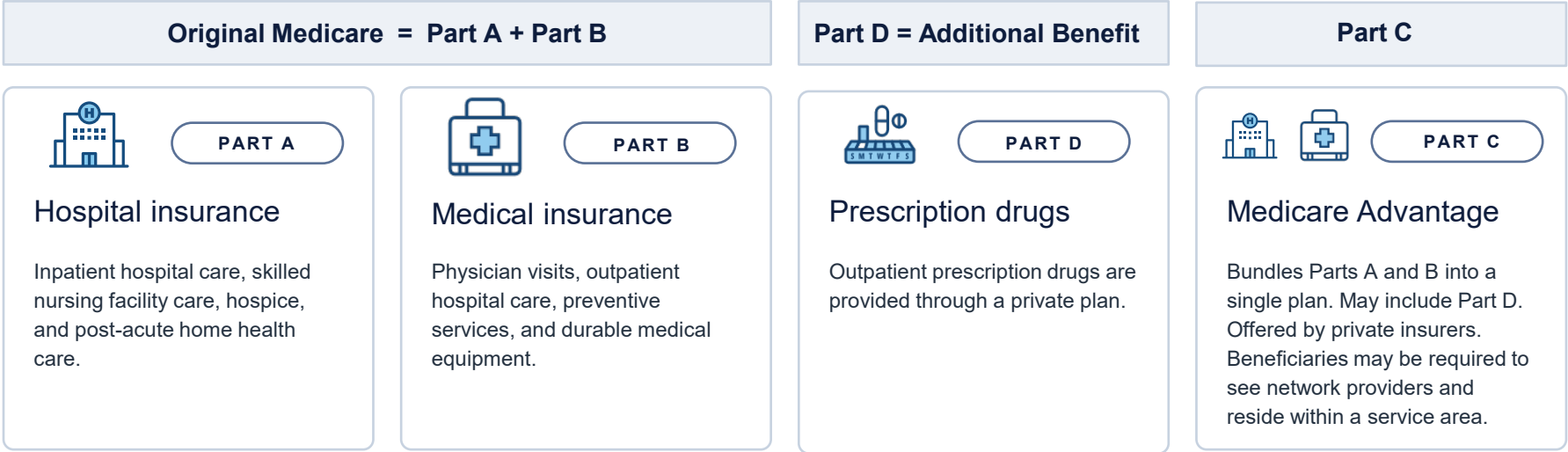
Above those thresholds, total monthly Part B premiums range from \$284.10 to \$689.90 depending on income.

Part D income-related monthly adjustment amounts (IRMAA) range from \$14.50 to \$91.00 per month and are paid in addition to the plan premium.

Roughly 8% of beneficiaries pay the income-related monthly adjustment amount (IRMAA).

Source: Centers for Medicare & Medicaid Services, 2026 Medicare Parts A & B Premiums and Deductibles, November 14, 2025.

The Four Parts of Medicare



Part D: Prescription Drug Coverage

What it Covers	Cost Sharing
• Outpatient prescription drug coverage and vaccines • Available as part of a Medicare Advantage plan or a stand-alone prescription drug plan	• Premium varies by plan and covered prescriptions • Prescription copays apply • Maximum out-of-pocket cost for 2026 is \$2,100

A plan’s formulary can change during the year with notice.

Medicare Coverage Options Individual and Group

Medicare Advantage (Part C) Plans

Medicare Advantage is an all-in-one alternative to Original Medicare, offered by private insurers under contract with CMS.

Bundled Coverage

One private plan provides Part A and Part B benefits, and most plans include Part D prescription drug coverage. Many value-added benefits such as dental, vision, and hearing.

Provider Network

Care is generally limited to the plan's network and service area, and some services need a referral or prior approval before the plan will pay.

Plan Costs

Beneficiaries pay the Part B premium plus any plan premium. Copays may apply, but yearly out-of-pocket costs are capped.

CMS pays each Medicare Advantage plan a fixed monthly amount per enrollee, set by the county benchmark, the plan's own bid, any rebate the plan must spend on extra benefits, and a risk adjustment for the member's health — so payment varies.

Medicare Supplement (Medigap) Plans

Medicare Supplement (Medigap) is optional private insurance that helps cover out-of-pocket costs not paid by Original Medicare

Fills the Gaps

After Original Medicare pays its portion of covered expenses, Medicare Supplement (Medigap) plans help pay many remaining out-of-pocket costs, including deductible, coinsurance and copayments. May also cover benefits such as vision and dental.

Works Alongside Medicare

Medicare Supplement (Medigap) plans do not replace Original Medicare coverage. Beneficiaries may seek services from any provider who accepts Medicare.

Monthly Premiums

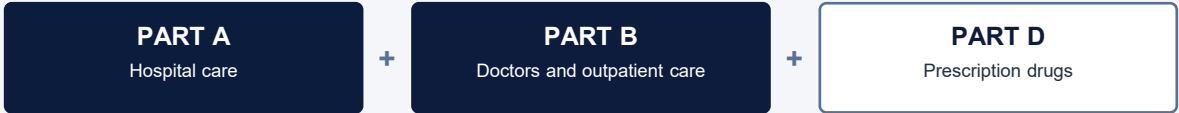
Vary by plan, insurer and location. Paid in addition to the Medicare Part B premium. Part D prescription drug coverage is purchased separately.

Medicare Advantage vs. Medicare Supplement

	Medicare Advantage (Part C)	Original Medicare + Medicare Supplement
How it works	A private plan replaces Original Medicare and administers Parts A and B benefits.	The policy sits alongside Original Medicare and pays the costs (gaps) Medicare leaves behind.
Funding	CMS pays the plan a set amount per enrollee each month. Plan premium and co-pays may apply.	Member premiums fund the policy. CMS pays only Medicare's share of each claim.
Provider access	Generally limited to the plan's network, with referral or prior authorization rules.	Any provider nationwide that accepts Original Medicare.
Outpatient Prescriptions	Often includes Part D.	No drug coverage. A separate Part D plan is needed.
Supplemental Benefits	May include dental, transportation, meal delivery, gym membership, etc.	May include dental, transportation, meal delivery, gym membership, etc.
A beneficiary can choose Medicare Advantage or pair Original Medicare with a Medicare Supplement (Medigap) policy, but not both.		

Medicare Coverage Options for Individuals

Original Medicare plus a drug plan



Parts A and B with a Part D plan added. Without a Medicare Supplement policy, beneficiary pays Medicare's deductibles and coinsurance.

Original Medicare, Medicare Supplement, and a drug plan



A Medicare Supplement policy covers the gaps Original Medicare leaves, with a separate Part D plan for prescriptions.

Medicare Advantage



One private plan bundles Parts A and B, and prescription drug coverage is often included.

Why Employers Sponsor Retiree Health Coverage

Many employers began offering retiree health coverage before Medicare existed, and those that still offer it do so for workforce, contractual, and cost-management reasons.

Recruitment and Retention	Support Workforce Aging	Historical or Union Commitments
• Retiree coverage can be a recruitment tool and part of a competitive total rewards package. • Helps attract and keep experienced staff, especially where salaries may trail the private sector. • A predictable benefit rewards long service and career employment.	• Manage plan design benefits • Negotiate plan premiums • Gives employees a path to retire on schedule instead of working to keep coverage. • Bridges coverage for those who retire before becoming Medicare eligible.	• Many programs date to the 1950s and 1960s, before Medicare existed. • Benefits are often set by collective bargaining agreement, charter, or long-standing policy. • Changes generally require negotiation or governing board action.

Group retiree coverage also gives employers purchasing leverage, letting them shape plan design and negotiate premiums on behalf of the retiree population

Employer-Sponsored (Group) Medicare Options

Group Medicare Advantage	Group Medicare Supplement (Medigap)	Group Part D
• The employer contracts with a private insurer to provides Medicare-covered benefits. • The employer sponsors the plan and funds all or part of the plan premium. • Plan types may include HMO or PPO arrangements with network requirements. • The employer determines the plan design. • The employer may add supplemental benefits. • Often includes Part D.	• The employer sponsors coverage that pays cost sharing remaining after Original Medicare pays. • The employer funds all or part of the plan premium; the arrangement may be insured or self-funded. • The employer determines the plan design. • The employer may add supplemental benefits. • Prescription drug coverage is arranged separately.	• The employer sponsors a group prescription drug plan for retirees. • The employer funds all or part of the plan premium. • The employer determines the plan design. • Each plan maintains its own formulary under rules set by CMS.

Retiree beneficiaries may still pay a Part B premium, their portion of the Medicare Supplement or Medicare Advantage premium, and relevant coinsurance or copayments.

Retiree Should Weigh Their Options

Retirees Should Weigh Their Options

- Total member cost
- Benefits and prescriptions
- Provider access
- Plan rules and coordination

Retirees Should Weigh Their Options – Member Cost

Total member cost

- What premiums apply, including the Part B premium and any plan premium?
- What deductibles, copayments, and coinsurance would be paid during the year?
- Is there an annual limit on out-of-pocket costs?
- Would an income-related adjustment apply to the Part B or Part D premium?

Retirees Should Weigh Their Options – Provider Access

Provider Access

- Which providers and facilities may be used, and is a network or service area required?
- Are referrals or prior authorization required for certain services?
- Does coverage travel outside the service area or outside the United States?
- What happens to coverage after a move to another county or state?

Retirees Should Weigh Their Options - Benefits

Benefits and prescriptions

- How is prescription drug coverage provided, and is it built into the plan or purchased separately?
- Are current medications on the plan formulary, and at what tier?
- Which benefits beyond Medicare-covered services are included, such as eyewear, hearing aids, dental, and fitness?

Retirees Should Weigh Their Options – Plan Rules and Coordination

Plan rules and coordination

- Is the choice Medicare Advantage or Original Medicare paired with a Medicare Supplement (Medigap) policy? How does the coverage coordinate with Medicare and with any separate policies?
- When can enrollment or a plan change be made, and would purchasing a Medicare Supplement plan later require medical underwriting?
- How would enrolling in an individual plan affect eligibility for employer group retiree coverage?

SFHSS Medicare Plans

Current State, Historical Context and Future Plan Decisions

Health Service Board Considerations When Selecting Plans



1. Member Experience
 - Prior Authorizations
 - Plan Offerings and Affordability
 - Care Navigation and Coordination
2. Employer Financial and Administrative Implications
 - Plan Offerings and Affordability
 - Other Post-Employment Benefits (OPEB) Impacts
 - SFHSS Administrative Feasibility
3. Decision Framework

Consideration #1 – Member Experience

Prior Authorizations

Health Plans require Prior Authorizations to:

Ensure Patient Safety

Control Financial Costs

Improve Claim Reliability

January 2026 — Centers for Medicare and Medicaid Services

Reduced the required response time for prior authorization decisions to be made from **14-day standard to 7 calendar days** and within **72 hours for expedited requests**. Payers are now required to provide member-specific denial rationale and publicly report approval, denial, and appeal-overturn rates on the health plan’s website.

Plan	Expedited Authorization Requests	Standard Authorization Requests
Blue Shield MAPD PPO	96.3% Approved Decisions made = average 31 hrs.	90.6% Approved Decisions made = average in 4 days.
Kaiser Senior Advantage HMO	95.4% Approved Decisions made = average in 23 hrs.	90.6% Approved Decisions made = average in 2 days.

Consideration #1 – Member Experience

Plan Offerings and Affordability

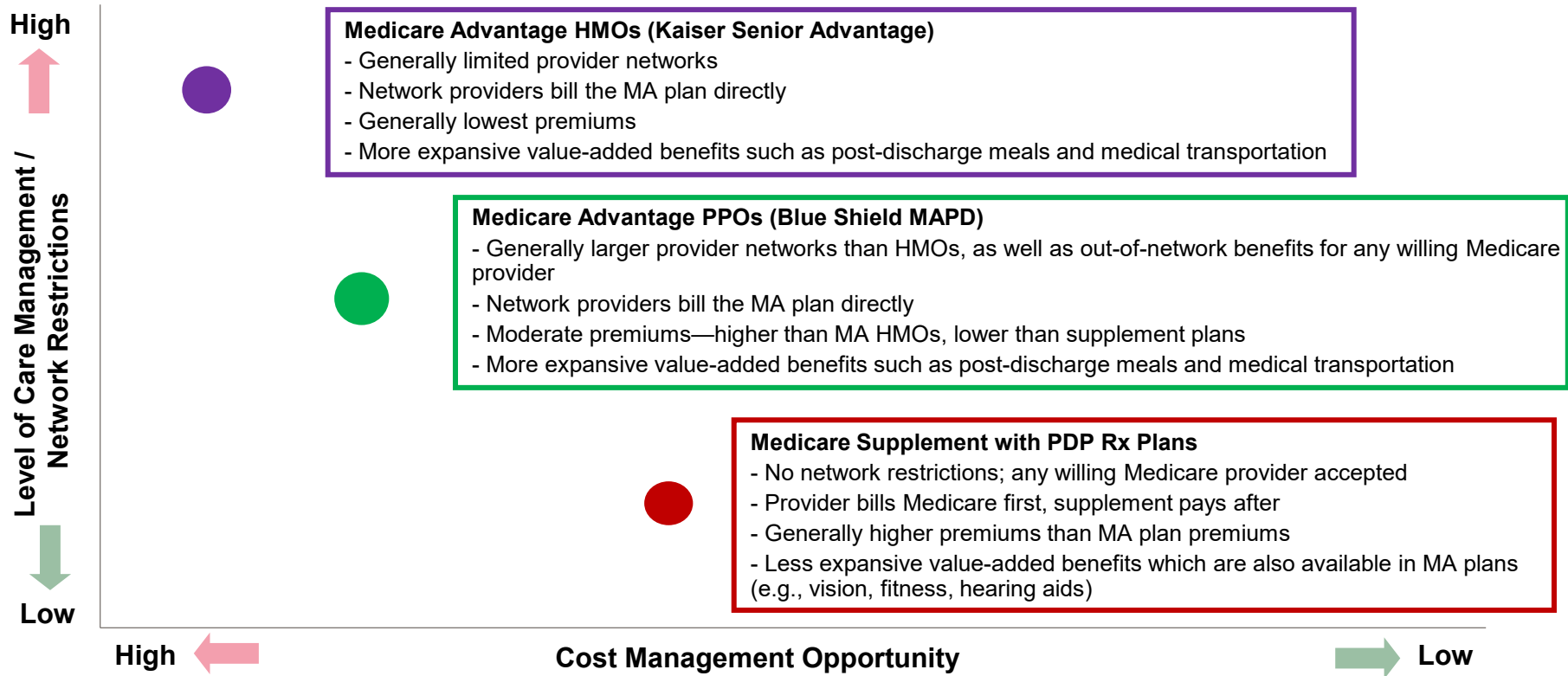
Since January 1, 2025, Medicare retirees have been offered the following two (2) plans for medical and prescription drug coverage:

- 1 fully insured Medicare Advantage HMO Plan
 - Kaiser Permanente Senior Advantage (KPSA)

- 1 fully insured Medicare Advantage PPO Plan
 - Blue Shield of California Medicare Advantage with Prescription Drug (MAPD) PPO

Consideration #1 Member Experience

Care Navigation and Coordination



Consideration #1 – Member Experience: Plan Offerings and Affordability

Cost of Coverage for Blue Shield MAPD 2026

Total Monthly Premium Costs and Member Contributions in 2026 for Blue Shield MAPD Plan:

Retiree Only (Monthly)

Hire date & Service	MAPD Total Cost	Retiree Pays	City Pays
Before 1/9/2009 or 20+years	\$569	\$0	\$569
After 1/9/2009, 15–19 years	\$569	\$142	\$427
After 1/9/2009, 10–14 years	\$569	\$284	\$285
After 1/9/2009, 5–9 years	\$569	\$569	\$0

Retiree +1 Dependent (Monthly)

Hire date & Service	MAPD Total Cost	Retiree Pays	City Pays
Before 1/9/2009 or 20+years	\$1,131	\$281	\$850
After 1/9/2009, 15–19 years	\$1,131	\$494	\$637
After 1/9/2009, 10–14 years	\$1,131	\$706	\$425
After 1/9/2009, 5–9 years	\$1,131	\$1,131	\$0

Consideration #1 – Member Experience

Care Navigation and Coordination

Patient experience differs by who helps coordinate the member’s care.

	Medicare Advantage	Medicare Supplement
Care Coordination	Plan may organize care through referrals, care managers, or plan support.	Member and providers coordinate across clinicians.
Proactive Outreach	Includes health assessments, reminders, and care-gap outreach.	Typically, less plan-initiated assessment and care-gap outreach.
Managing Conditions	Includes disease management, case management, or medication review.	Primarily helps with cost sharing, not managing conditions.
Care Navigation	Central plan resource can help, but may include network, referral, or authorization rules.	Member may do more confirming and scheduling.
Transitions of Care	Includes post-discharge outreach, medication reconciliation, and next-step reminders.	Follow-up depends on discharge plan, PCP, and member/caregiver action.

Consideration #2 – Employer Financial and Administrative Implications

Plan Offerings and Affordability

Past Plan Options Count Over Time

Through 2015 – 3 Plans	2016 – 4 Plans	2017 – 2 Plans
Three (3) plan options for medical and prescription drug coverage	Added a fully insured Group Medicare Advantage PPO plan to the existing plan	Narrowed offerings to two plan options Terminated: Blue Shield 65 Plus Plan and the City Plan*
Medicare Advantage HMO (fully insured) – 2 plans • Kaiser Senior Advantage • Blue Shield 65 Plus Medicare Supplement / Medigap PPO + separate Rx (self-funded) – 1 plan • City Health Plan (UnitedHealthcare Choice Plus with Medicare Rx for Group)	Medicare Advantage HMO (fully insured) – 2 plans • Kaiser Senior Advantage • Blue Shield 65 Plus Medicare Supplement / Medigap PPO + separate Rx (self-funded) – 1 plan • City Health Plan (UnitedHealthcare Choice Plus with Medicare Rx for Group) Medicare Advantage PPO with Rx / MAPD (fully insured) – 1 plan • UnitedHealthcare Medicare Advantage National PPO	Medicare Advantage HMO (fully insured) – 1 plan • Kaiser Senior Advantage Medicare Advantage PPO with Rx / MAPD (fully insured) – 1 plan • UnitedHealthcare Medicare Advantage National PPO <i>*30% premium increase would have been required to sustain the Medicare Supplemental City Plan Year 2017.</i>

Consideration #2 – Employer Financial and Administrative Implications

Other Post-Employment Benefits (OPEB) Impacts

- OPEB is Other Post-Employment Benefits. It refers to the non-pension benefits that public and private-sector employees receive when they retire—most notably retiree healthcare, but also life insurance, dental, and vision coverage.
- For decades, employers used pay-as-you-go (PAYGO) accounting for OPEB. They only recorded the cost of healthcare for *current* retirees in their annual budget, completely ignoring the massive debt they were accumulating for *future* retirees.
- In the 1980's through 2000, public and private employers began offering more and more comprehensive retiree healthcare packages for several reasons:
 - Coverage bridge between date of retirement and Medicare eligibility for early retirees, especially public safety
 - Employee recruitment and retention
 - Relatively low cost at that time to provide these future benefits when they were first promised to an employee

Consideration #2 – Employer Financial and Administrative Implications

What / When / Why Did OPEB Become a Challenge?

- By the early 2000s, three major factors collided to create an economic emergency for many public agencies:
 - **Exploding Healthcare Costs:** Medical inflation began rising at annual rates drastically outpacing the general economy, turning minor benefit promises into multi-billion-dollar liabilities.
 - **Demographic Shifts:** The massive Baby Boomer generation began approaching retirement age. At the same time, life expectancy increased. Suddenly, fewer active workers were paying into systems that had to support an increasing retiree population living—and drawing expensive medical benefits—for decades.
 - **Public Sector Plan Collapses:** A number of California cities and counties experienced catastrophic bankruptcies, leaving retirees at risk of being stripped of their promised healthcare benefits because the public agencies had failed to save money for them.

Consideration #2 – Employer Financial and Administrative Implication

Change in Accounting Rules for OPEB

New Accounting rules: In June 2004, the Governmental Accounting Standings Board (GASB) issued statement number 45 which required that state and local governments move from a cash (pay-as-you-go) basis for accounting to an accrual basis for the future expected value of retiree medical benefits on the employer's financial statements.

For City and County of San Francisco, OPEB actuary Cheiron performs the calculations annually and issues their annual actuarial report with plan liabilities each Fall after the June 30 close of a fiscal year. This weblink leads to the most recent available report: Governance Accounting Standard Board (GASB) [GASB-74-75-Report_6302025.pdf](#). Presently, the City's total OPEB liability is \$5.1 billion.

High liabilities make it more expensive for public agencies like the City and County of San Francisco to borrow money that support both ongoing expense needs and special one-time needs.

Consideration #2 – Employer Financial and Administrative Implications

How Public Employers Responded to the OPEB Burden

To balance these pressures, public agencies looked to several cost-management strategies:

1. **Prefunding** – Setting up an Irrevocable OPEB Trust (like a Section 115 Trust) to invest assets.
2. **Plan Design Reform** – Implementing two-tier systems where newer hires must work longer or contribute more to qualify for retiree health.
3. **Adjusting Plan Offerings** – Shifting Medicare retirees into Medicare Advantage plans to lower agency premium costs.

Consideration #2 – Employer Financial and Administrative Implication

San Francisco's Response - 2009 City Charter Change

- **Proposition B:** Passed by voters in June of 2008
- **The Purpose:** To reform retiree health care and pension benefits for City employees.
- **The Goal:** It aimed to address San Francisco's multi-billion-dollar unfunded liability for retiree healthcare.
 1. Increased the number of years new San Francisco public employees hired after January 9, 2009 would have to work to fully qualify for employer-subsidized health coverage,
 2. Established a Retiree Health Care Trust Fund, and
 3. Adjusted certain pension cost-of-living formulas.

Cost Comparison of Medicare Advantage vs Medicare Supplement Plan

The California Public Employees' Retirement System (CalPERS) is another large employer that handles benefits for public workers, schools, and local government agencies. CALPERS offers both Medicare Advantage and Medicare Supplement plans.

Its 2026 total monthly premiums are as follows:

- Cost of Retiree only Medicare Advantage Plans
 - Kaiser Senior Advantage HMO – \$357
 - Blue Shield MAPD PPO – \$539

- Cost of Retiree only Medicare Supplement PPO Plans
 - PERS Gold Medicare Supplement PPO (Blue Shield) – \$598
 - PERS Platinum Medicare Supplement PPO (Blue Shield) – \$666

[CalPERS 2026 Region 1 Health Premiums \(Actives and Annuitants\) \(PDF\)](#)

Monthly Cost Comparison: Blue Shield MAPD (2026) vs. Medicare Supplemental Plan (Illustrative Scenario)

Retiree Only: MAPD \$569 / Supplement \$706; Retiree + 1 Dependent: MAPD \$1,131 / Supplement \$1,402

Retirees pay the amounts shown below; the remaining premium is employer-funded.

Supplement illustration reflect a scenario priced 24% more expensive than MAPD.

Retiree Only (Monthly)

Hire date & Service	MAPD (2026)	Supplement (Illustration*)	Retiree Cost Difference
Before 1/9/2009 or 20+years	\$0	\$0	\$0
After 1/9/2009, 15–19 years	\$142	\$177	+\$35
After 1/9/2009, 10–14 years	\$284	\$353	+\$69
After 1/9/2009, 5–9 years	\$569	\$706	+\$137

Retiree +1 Dependent (Monthly)

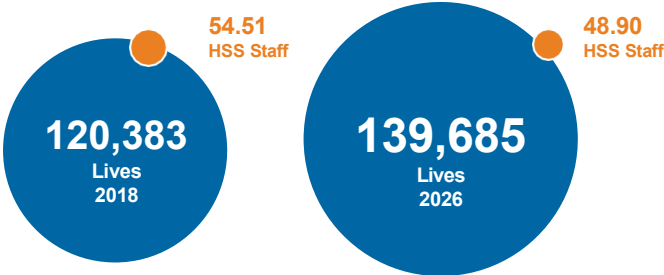
Hire date & Service	MAPD (2026)	Supplement (Illustration*)	Retire Cost Difference
Before 1/9/2009 or 20+years	\$281	\$348	+\$67
After 1/9/2009, 15–19 years	\$494	\$612	+\$118
After 1/9/2009, 10–14 years	\$706	\$875	+\$169
After 1/9/2009, 5–9 years	\$1,131	\$1,402	+\$271

*Illustrative only: Supplemental shown at 24% above MAPD, based on the observed CalPERS differential.

Consideration #2 – Administrative Feasibility

Staff Resources

Since 2018, SFHSS staff levels are down **10%**, all medical lives up **16.03%** The recent layoffs included a 1652 position which was responsible for these premium payments.



Lives to HSS Staff			
	2018	2026	% Change
Lives	120,383	139,685	+16.03%
HSS Staff	54.51	48.90	-10%

Consideration #2 – Administrative Feasibility Challenges

Adding a plan to HSS's plan lineup would require additional staff resources.

- **Annual maintenance**

- Review and approve all plan documents / collateral.
- Master application.
- Independent state regulatory requirements.
- Benefit administration system configuration and testing.
- Detail rate calculations and programming.
- Payment system updates.
- Required disclosures.
- Governmental Accounting Standards Board (GASB) required audits and other regulatory reporting.

Consideration #2 – Administrative Feasibility Challenges

- **Ongoing Maintenance – Weekly / Monthly**
 - Payment discrepancy reports – premium reconciliation.
 - Enrollment discrepancy reports – Medicare compliance / enrolled – disenrolled.
 - Staff must be able to provide details on the unique additional plans – due to low demand, increased contact time is necessary to provide explanation.

Consideration #3 – Decision Framework

Comparing Tradeoffs between the Current MAPD PPO and a Medicare Supplement plan

Decision Factor	Current MAPD PPO	Medicare Supplement	Favorable Value
Provider Access	Broad (Any Willing Provider)	Broad (Prior City Plan had In/Out-of-Network)	Broad under both; different rules
Prior Authorization	Applies	Generally Less	Medicare Supplement
Supplemental Benefits	Included	Requires Separate Coverage	MAPD PPO
Annual Member Protection	Must contain Maximum Out of Pocket protections	Depends on Medigap plan design; higher premium may provide lower point-of-service cost	MAPD PPO
Employer Premium	Current known cost	Expected higher	MAPD PPO
OPEB Exposure	Current Baseline	Expected higher	MAPD PPO
Administration	Existing structure	Added complexity and reconciliation	MAPD PPO
Care Management	Included	Primarily cost-sharing; less plan-directed care management	MAPD PPO

Consideration #3 – Decision Framework

Why the Current MAPD PPO Continues to Fit SFHSS Needs



Cost Affordability: Medicare Supplement plans generally carry much higher monthly premiums for the employer and generally expose it to higher healthcare inflation. Medicare Advantage PPO group plans typically offer lower premiums and predictable copayments.



Simplified Administration: A Medicare Advantage PPO allows the agency to keep working with a single private plan administrator or carrier framework rather than needing to manage a completely separate Original Medicare plus supplemental coordination structure.



Retained Flexibility over HMOs: A Medicare Advantage PPO option satisfies retirees who reject the rigid network constraints of the Kaiser Medicare Advantage HMO, without assuming the higher expected premium and additional financial exposure associated with the Supplement scenarios reviewed.

Summary

Medicare Basics	Considerations for Future Plan Decisions
• Original Medicare • The various parts of Medicare • Medicare coverage options and combinations for both individuals and employer group coverage	• Medicare plan decision factors • Explanation of why OPEB must be considered for benefit changes that would increase future costs • Cost-benefit analysis of changing Medicare plans

Appendix

How CMS Pays Medicare Advantage Plans

CMS pays each Medicare Advantage plan a fixed amount per enrollee per month. Four concepts determine that amount.

1

County benchmark

CMS sets a maximum payment rate for each county, based on the cost of caring for a beneficiary under Original Medicare in that market.

2

Plan bid

An insurer submits a bid representing its cost to provide Medicare-covered benefits to an enrollee.

3

Rebate

If the bid falls below the benchmark, the plan receives a share of the difference and is required to apply it to additional member benefits or reduced cost sharing.

4

Risk adjustment

The payment is adjusted by a risk score reflecting the individual enrollee's health status, so payment varies by enrollee.

Premium amounts are set by the county benchmark, the plan's own bid, any rebate the plan must spend on extra benefits, and a risk adjustment for the member's health — so payment varies.