<u>Medicare Advantage and Part D Rate Summary</u>

<u>Years 1 – 5 Medicare Advantage Rate Guarantee</u> – Best and Final Offer

The chart below outlines the Aetna Medicare Advantage (MA) plan guaranteed rates for the initial 5-year Contract period 9/01/2023– 8/31/2028 on a per member per month (PMPM) basis. The commercial group health plan offered by the City of New York (the "City") to its Medicare-eligible retirees and their dependents that includes coverage for supplemental benefits that are secondary to original Medicare is referred to in this Attachment B as the "Supplement Plan".

Plan: Medicare Advantage (C04) ESA PPO	**Option A**: Full Replacement; No other plan offered*	**Option B**: Default plan; eligible retirees/dependents can opt into Supplement Plan at full additional incremental cost	**Option C**: Default plan; eligible retirees/dependents can opt into Supplement Plan at NO additional cost
09/01/2023 – 12/31/2023 Guaranteed Rate ($ PMPM)	$0.00	$0.00	$20.00
Plan Year 2024 Guaranteed Rate ($ PMPM)	$0.00	$0.00	$20.00
Plan Year 2025 Guaranteed Rate ($ PMPM)	$0.00	$0.00	$20.00
Plan Year 2026 Guaranteed Rate ($ PMPM)	$0.00	$0.00	$20.00
Plan Year 2027 Guaranteed Rate ($ PMPM)	$0.00	$0.00	No rate guarantee
01/01/2028 – 08/31/2028 Guaranteed Rate ($ PMPM)	$0.00	$0.00	No rate guarantee

*As acknowledged by Aetna during the procurement for Medicare Advantage Services, the City intends for the HIP VIP to continue to be offered as a City Medicare plan to Medicare eligible City retirees.

The parties agree that if at some point in the future, a Supplement product is offered with a partial subsidy provided to some or all of the retirees, the parties agree to work together to achieve a mutually agreeable Premium to be assessed on a per member per month basis. In the event that the parties cannot reach an agreement, the parties agree to initiate the previously agreed to dispute resolution process described in this document, which would begin with the Actuarial review process that has been established for the "Legislative, Regulatory, or CMS Changes or Enforcement action" section.

Years 6 – 11 MA Rate Guarantee – **Best and Final Offer**

For Options A and B as defined above, the chart below outlines the Aetna MA plan guaranteed rate increase structure for Contract years 6 – 11, with the Contract year 6 starting 09/01/2028, subject to the conditions below:

<table>
<tr><th>CMS Reimbursement Change for Renewal Year
(Positive number equals increase;
negative number equals decrease)</th><th>Guaranteed Rate
Year 6
(9/1/28 – 12/31/29)*</th><th>Maximum Annual Rate Increase
$PMPM for Renewal Years **
7, 8, 9, 10, and 11</th></tr>
<tr><td>5.00% or greater</td><td rowspan="8">$0.00</td><td>$5.00</td></tr>
<tr><td>4.00 - 4.99%</td><td>$10.00</td></tr>
<tr><td>3.00 - 3.99%</td><td>$15.00</td></tr>
<tr><td>2.00 - 2.99%</td><td>$20.00</td></tr>
<tr><td>1.00 - 1.99%</td><td>$25.00</td></tr>
<tr><td>0.00 - 0.99%</td><td>$30.00</td></tr>
<tr><td>(1.00%) - (0.01%)</td><td>$35.00</td></tr>
<tr><td>(1.01%) or less</td><td>TBD ***</td></tr>
<tr><td colspan="3"></td></tr>
<tr><td colspan="3">* Assumes the projected MA MLR for the year prior to the renewal is less than 93.27%. If the projected MA MLR is greater than or equal to 93.27%, a rate increase will be allowed, up to a maximum increase of up to $30 per member per month. The new rate would become effective at the beginning of the 16month period beginning 9/1/2028. The City will be notified of any rate increase for Year 6 by 2/1/2028.</td></tr>
<tr><td colspan="3">** Assumes projected MA MLR for the year prior to the renewal year is less than 93.27%. If projected MA MLR is greater than or equal to 93.27%, maximum rate increases do not apply, and rate increase will be determined at time of renewal.

MA MLR as defined in the Retrospective Experience Refund Agreement enclosed document.</td></tr>
<tr><td colspan="3">*** Maximum rate increases do not apply, and rate increase will be determined at time of renewal</td></tr>
</table>

To tie the Contract and MA plan to a traditional 1/1 calendar-year MA plan benefit cycle, at the end of the initial 5-year and 4 month Contract term, the $0 rate for the initial 5-year Rate

Guarantee period will be extended for another 1 year and 4 months through 12/31/29, assuming the City or Aetna do not choose to terminate the Contract sooner.

The components of CMS reimbursement that will be considered for this purpose include:

- Fee for Service (FFS) and Medicare Advantage (MA) Growth Rates- (CMS-defined component of percentage increases to MA rates based on CMS-estimated claims trend)
- FFS county-level cost re-basing- (CMS-derived annual changes to county-level benchmark values released within the CMS ratebook document)
- Coding Intensity Adjustment- (CMS-defined adjustment to revenue risk scores related to estimated differences in coding patterns between Medicare Advantage and Medicare FFS members nationwide)
- Hierarchical Condition Categories (HCC) model changes and/or recalibration- (changes to calculation mechanisms of CMS HCC model that result in changes in risk scores even with the same input set of member-level health conditions)
- FFS Normalization- (CMS-defined adjustment applied to risk score calculations to account for an estimated difference in underlying health conditions of MA members in plan year to FFS member data in HCC model development)
- Sequestration- (CMS-defined adjustment to revenue based on congressional action that lowers MA rates below statutorily required rating)
- Bid-to-benchmark ratios used in the CMS Group Medicare Advantage payment methodology- (CMS-defined county-level adjustments used to calculate payment rates for employer group retiree plans)
- Any changes to the Group Medicare Advantage payment methodology, including new CMS-defined factors or adjustments, that impact CMS payment rates by more than 0.5%

A factor that will not be considered for this purpose is the impact of efforts to collect and submit data to CMS that determines CMS risk scores, also known as coding trend. Aetna has already factored coding trend into the rate guarantee.

Notwithstanding the above, Aetna assumes the risk and will honor the rate structure above if Aetna fails to qualify for MA Quality Bonus Payments provided the Bonus Payments program remains in effect. (i.e., Aetna takes the risk of failure to qualify for the Bonus Payments program).

<u>Years 7 – 11 MA Renewal Rate Development</u> For purposes of calculating the City's renewal supplemental premium rates, Aetna will hold the City harmless by continuing to calculate renewal supplemental premium rates using an assumption of revenue at the 4 Star level in the event Aetna falls below this Star-based quality bonus threshold due to Aetna's under-performance, but not if Aetna loses its Star-based quality bonus due solely to changes in CMS qualification criteria (cut points, metrics, weights, etc.)

Medicare Advantage Renewal Pricing Methodology: Aetna will develop renewal pricing using the most recent 12 months of incurred completed claims trended forward to the midpoint of the renewal plan year. A pooling charge will be added to this amount and a pooling credit based on actual experience will be deducted to arrive at the Adjusted Projected Incurred Claims. The Adjusted Projected Incurred Claims will be divided by the Target Cost Ratio (to add expenses) resulting in Required Revenue (before taxes, fees and assessments). From the Required Revenue (before taxes, fees, and assessments) the Projected Quote Year CMS Revenue is subtracted and then taxes, fees and assessments are added to arrive at the Required Supplemental Premium.

Calculation based on per member per month cost:

Incurred and completed claims for the most recent 12 months × annual trend (trended to the midpoint of the renewal period) + pooling charge – pooling credit = Adjusted Projected Incurred Claims.

Adjusted Projected Incurred Claims ÷ Target Cost Ratio = Required Revenue (before taxes, fees, and assessments)

Required Revenue (before taxes, fees, and assessments) – Projected Quote Year CMS Revenue + taxes, fees and assessments = Required Supplemental Premium

Rates quoted for subsequent renewal terms beyond the initial term ending 12/31/2029 are subject to change and mutual agreement of the parties.

For annual renewal terms with an effective date beginning on or after 1/1/2035 (defined as "Additional Subsequent Terms" in the Contract), rates for annual renewal pricing will be developed using the "Medicare Advantage Renewal Pricing Methodology" described above and all financial conditions described herein. Rates for such Additional Subsequent Terms are subject to change and mutual agreement of the parties.

<u>2023 – 2024 PDP Rate Guarantee</u> – Best and Final Offer

The proposal assumes that effective 1/1/2024, the Aetna PDP plan is the only group-sponsored Part D plan offered by the City, with the exception of the group-sponsored Part D plan offered as part of the VIP Premier HMO Medicare Advantage plan described at this link: https://www.emblemhealth.com/resources/city-of-new-york-employees/vip-premier-hmo-medicare

The chart below outlines the Aetna standalone Medicare prescription drug plan (PDP) guaranteed premium rates for 09/01/2023 – 12/31/2024 on a per member per month (PMPM) basis.
2024 guaranteed premium rates include the impact of changes to Direct and Indirect Remuneration (DIR) requirements made through the Calendar Year 2023 Medicare Advantage and Part D final rule ("Final Rule"), and changes to the Part D program due to the passage of the Inflation Reduction Act of 2022 (the "Act").

The 2024 plan design is updated (enriched) to comply with the Act as follows:
- $0 member cost share for Part D covered vaccines
- Member cost share may not exceed $35 for a one month's supply of formulary covered insulin
- $0 member cost share in the catastrophic phase of coverage (post-TrOOP)

	RFP Requested Plan Rx 0%/25%/25%/25%/25%	**Plan Eligibility**
09/01/2023 – 12/31/2023 Guaranteed Rate ($ PMPM)	$103.50	Members who are enrolled in a group health plan (other than the GHI/Empire Blue Cross Blue Shield (EBCBS) Senior Care Plan) offered by the City or an individual standalone Medicare prescription drug plan prior to the Effective Date
Plan Year 2024 Guaranteed Rate ($ PMPM)	$135.50	Plan available for all members

Part D (PDP) Renewal Pricing Methodology: Aetna will develop PDP renewal rates using 12 months of calendar year Member-level claim detail, trended forward to the renewal plan year minus Member cost share minus expected value of manufacturer's discount program minus expected value of CMS reinsurance to project the claim liability.

The projected claim liability will then be divided by the target cost ratio (to add expenses) to calculate total required revenue, and then CMS expected revenue will be removed to develop the supplemental premium. If applicable, any taxes, fees and assessments will be added to the supplemental premium.

Calculation based on per member per month cost:
Annual claims × annual trend (trended to the midpoint of the renewal period) - expected value of Member cost share -expected value of manufacturer's discount program - expected CMS reinsurance = Projected Claim Liability.

Projected Claim Liability ÷ Target Cost Ratio = Total Required Revenue
Total Required Revenue - Projected Quote Year CMS Revenue = Required Premium

Aetna agrees to make best efforts around mitigating rate changes (e.g., negotiation of prescription drug prices with pharmaceutical manufacturers).

<u>2025 – 2028 PDP Total Required Revenue Guarantee</u> – Best and Final Offer

The initial Part D Contract period ends on 12/31/2028.

City of New York
Attachment B: Medicare Advantage and Part D Rate Summary

The chart below outlines the Aetna Part D guaranteed renewal guarantee structure subject to the conditions below.

The 2025 plan design is updated (enriched) to comply with the Act as follows:
- $0 member cost share for Part D covered vaccines
- Member cost share may not exceed $35 for a one month's supply of formulary covered insulin
- $2,000 member out-of-pocket maximum

The 2026 – 2028 plan designs include an annual increase in the member out-of-pocket maximum as set forth in the Act.

The CMS Revenue (monthly risk-adjusted direct subsidy) for beneficiaries enrolled in Part D Employer Group Waiver Plans (EGWPs) is an outcome of the Individual Market Part D bidding process; historically, CMS has announced the outcome of the bid process approximately five months prior to the plan year effective date (e.g., announced on July 29, 2022 for plan year 2023).

Aetna guarantees the Total Required Revenue and maximum increases as set forth in the chart below. Once CMS announces the direct subsidy amount for the upcoming plan year, Aetna will subtract the expected CMS Revenue from the Total Required Revenue and provide the City with a guaranteed premium rate.

	RFP Requested Plan * Rx 0%/25%/25%/25%/25%
Plan Year 2025 Total Required Revenue Guarantee ($ PMPM)	$259.73
Plan Year 2026 Guaranteed Maximum Total Required Revenue Increase ($ PMPM)	+$25.28
Plan Year 2027 Guaranteed Maximum Total Required Revenue Increase ($ PMPM)	+$27.79
Plan Year 2028 Guaranteed Maximum Total Required Revenue Increase ($ PMPM)	+$30.54

* Assumes projected Part D MLR for the year prior to the renewal year is less than 97.0%. If projected Part D MLR is greater than or equal to 97.0%, maximum rate increases do not apply, and rate increase will be determined at time of renewal.

Part D MLR = (Net Claims + Administrative Expense) / Revenue
- Net Claims = claims net of Member cost share, low income cost share, rebates, manufacturer's discounts, and net federal reinsurance
- Administrative Expense for Part D for 2025 is $8.74 PMPM and then trended forward at 3% per year plus any taxes, fees, or assessments

Revenue = Premium rates + risk adjusted direct subsidy

Note: Part D risk adjusted direct subsidy may be negative (fall below $0) during the contract period and is factored into the premium rates and MLR.

Assumes that the parties mutually agree to the formulary in advance for each year. The Open formulary provides open access to all Part D drugs and must be reviewed for clinical appropriateness and financial impact of coverage, including but not limited to new-to-market therapies.

Rates quoted for subsequent renewal terms beyond the initial Contract period are subject to change and mutual agreement of the parties.

Conditions for the MA and PDP Guarantees

We reserve the right to revise or remove the guarantees if any of the following conditions are not met:

Pricing and underwriting basis: Aetna submits this proposal, including the assumptions relating to Member enrollment for each plan set forth below, and all of the pricing and obligations assumed in it under the understanding that the Aetna group retiree benefits as included in this proposal is and will continue being the only Medicare Advantage plan for all current and future retirees from any source or other entity.

- Option A: Full Replacement: As of September 1, 2023, Aetna group retiree benefits are a full replacement and the only group plan* available for all current retirees subject to this Request for Proposal. All current retirees will be defaulted into the Aetna Medicare Advantage plans and must opt out if they want an individual market plan. Assumed enrollment in the Aetna plan is the entire population of City Medicare-eligible retiree members, excepting those that opt for the HIP-VIP MA plan.

- Option B: As of September 1, 2023, Aetna's group retiree benefits are offered as the only Medicare Advantage plan for eligible retirees and dependents alongside the Supplement * and that eligible retirees/ dependents will be defaulted into Aetna's Medicare Advantage plan but will have the ability to request opting back into the Supplement Plan at the full cost of the difference.

- Option C: As of September 1, 2023, Aetna's group retiree benefits are offered as the only Medicare Advantage plan for eligible retirees and dependents alongside the Supplement Plan* and that eligible retirees/dependents will be defaulted into Aetna's Medicare Advantage plan but will have the ability to request opting back into the Supplement Plan at no cost to the eligible retiree/dependent.

*As acknowledged by Aetna during the procurement for Medicare Advantage Services, the City intends for the HIP VIP to continue to be offered as a City Medicare plan to Medicare eligible City retirees.

- Benefit Plan Changes: If the City wants changes to their products, programs, or proposed benefit plans, then we will provide actuarial equivalent rate adjustments.

- Legislative, Regulatory or CMS Changes or Enforcement action: There are no legislative, regulatory or CMS changes or enforcement actions that individually or in the aggregate cause a material change to required benefits, funding levels or the manner and/or cost of providing Medicare Advantage or PDP coverage, including, but not limited to, implementation of the Risk Adjustment Data Validation Audit (RADV) rule as published on January 30, 2023, as may be amended from time to time, and any other related regulatory guidance ("Legislative Changes"). A Legislative Change will be considered "material" when the impact to the net cost to Aetna of the City of New York Medicare Advantage plan is estimated in good faith by Aetna to exceed 0.5% of the estimated average per member per month CMS Medicare Advantage revenue for the City of New York enrolled Aetna population in September 2023, and shall include cost impacts in increased benefit expenses, increased administrative burden expense, or decreased in CMS revenue, as calculated by Aetna for the City population (the "Estimated Impact"). To be perfectly clear, this clause is not meant to include normal annual changes to the well-defined CMS values and process that impacts rates, including the following key factors used in bid revenue development:

  - Fee for Service (FFS) and Medicare Advantage (MA) Growth Rates- (CMS-defined component of percentage increases to MA rates based on CMS-estimated claims trend)
  - FFS county-level cost re-basing- (CMS-derived annual changes to county-level benchmark values released within the CMS ratebook document)
  - Coding Intensity Adjustment- (CMS-defined adjustment to revenue risk scores related to estimated differences in coding patterns between Medicare Advantage and Medicare FFS members nationwide)
  - Hierarchical Condition Categories (HCC) model changes and/or recalibration- (changes to calculation mechanisms of CMS HCC model that result in changes in risk scores even with the same input set of member-level health conditions)
  - FFS Normalization- (CMS-defined adjustment applied to risk score calculations to account for an estimated difference in underlying health conditions of MA members in plan year to FFS member data in HCC model development)
  - Sequestration- (CMS-defined adjustment to revenue based on congressional action that lowers MA rates below statutorily required rating)
  - Bid-to-benchmark ratios used in the CMS Group Medicare Advantage payment methodology- (CMS-defined county-level adjustments used to calculate payment rates for employer group retiree plans)

In the event Aetna determines that there has been a Legislative Change with an Estimated Impact exceeding the 0.5% threshold, Aetna shall propose to the City a revised Rate, which shall take effect upon the effective date of the Legislative Change, including retroactively. Aetna agrees to share with the City the methodology and key data inputs used to calculate and demonstrate the Estimated Impact. In the event the City and Aetna cannot reach agreement on an impact value and/or materiality of a Legislative Change within 30 days of Aetna's notice of a revised Rate, the Parties will attempt to resolve the dispute using the below non-binding process before resorting to the dispute resolution procedure set forth in Section 12.03 of Appendix A. The City and Aetna will jointly hire three actuarial consulting/audit firms (choosing among Milliman, Wakely, Segal, PriceWaterhouse, and Deloitte)("Actuarial Consulting Firm(s)"). Each Actuarial Consulting Firm will independently review the Aetna developed rate increase ("Aetna rate increase") calculations and determine a recommended, actuarial sound rate increase for the Medicare Advantage plan that is certified by a Member of the American Academy of Actuaries, who is qualified to provide actuarial opinions on Medicare Advantage Employer Group Waiver Plan premium rates. If the average of the three rates provided by the Actuarial Consulting Firms is within 10% of the Aetna rate increase, the Aetna rate increase will stand; otherwise, the average of the premium rates calculated by the three Actuarial Consulting Firms will be the Medicare Advantage plan rate for the proposed rating period. Aetna will cover the cost for engagement of the Actuarial Consulting Firms. Pursuant to Section 12.03(C) of Appendix A to the Contract, Aetna agrees that during the pendency of the dispute resolution processes described in this paragraph, Aetna must continue to perform services in accordance with the Contract and as directed by the City.

- Implementation Allowance: We are including in the Aetna Medicare Advantage Plan ("Plan") costs an allowance of $3.93 per enrolled member per month up to a maximum of $6,000,000 for Option A, $3.93 per enrolled member per month up to a maximum of $6,000,000 for Option B, or $3.93 per enrolled member per month up to a maximum of $6,000,000 that may be used towards transition costs associated with implementing your new Plan. The parties acknowledge that transition costs associated with the implementation were effective July 1, 2021, the original contract award date.

  Plan eligibility: This proposal assumes all Members are retired and enrolled in Medicare Part A and Part B. If the City has Members who are not eligible for premium free Part A they must be enrolled in an Aetna Medicare Part B only plan and separate rates will be provided to cover these Members. Additionally, the City represents that actively working employees and their dependents are not permitted to enroll in the Aetna Medicare Advantage and/or standalone Medicare prescription drug plan(s) ("Plan(s)"), and that by offering the Plan(s) the City intends to create and maintain a retiree plan that is separate from the active plan.
- Broker commissions: Rating and guarantee calculations exclude any broker commissions. Any broker commissions would need to be added to these rates.

- Medicare Part D – Aetna reserves the right to change the Medicare Part D premium, total required revenue, or restructure the Part D plan design or formulary if any material changes are made to laws, rules, guidance, and/or regulations applicable to the Medicare Part D program. This includes, but is not limited to:

- elimination of safe harbor protection under the federal Anti-Kickback Statute (AKS) for drug manufacturer rebates or other price concessions
- establishment of new safe harbor protection under the AKS for certain point-of-sale reductions in drug pricing
- mandatory point-of-sale rebates / price concessions*
- changes to the drug manufacturer coverage gap discount program
- changes to federal Part D subsidies, including changes to catastrophic reinsurance
- drugs selected for Drug Price Negotiation
- statutory changes due to Part D reform**
- the Part D rebate rule is not repealed***

* The CMS annual MA and Part D Final Rule for plan year 2023 (“Final Rule”) eliminates post point-of-sale pharmacy price concessions. This policy will go into effect January 1, 2024. The PDP pricing provided herein reflects this Final Rule.

** The Inflation Reduction Act of 2022 (the “Act”) includes provisions that will result in Part D program changes for effective dates beginning in 2023. The PDP pricing provided herein may need to be adjusted to reflect future implementation or program guidance.

*** The Trump administration finalized a Part D manufacturer rebate rule in November 2020 that originally had an effective date of January 1, 2022. Most recent legislation has delayed the effective date to January 1, 2032. This rule has a sizeable impact on the Part D rates but may be reversed completely. The pricing that has been provided assumes that this Part D rebate rule will be fully repealed and, therefore, does not factor in any increase that would result from the change in rebate methodology. If this Part D rebate rule does take effect at a later date, the PDP pricing may be increased accordingly.

The premium developed in this proposal excludes any additional income-related Medicare Part D premium payments required of Medicare-eligible Members in order for the Member to be eligible for the Part D product.

Aetna reserves the right to communicate with Members regarding opportunities to reduce out of pocket prescription drug costs.

This guarantee assumes that our current experience-rating renewal methodology for groups with at least 400 subscribers will continue to be the accepted and approved methodology for renewals effective 2025. If this is not the case, this guarantee will be reviewed and may require revision.

The supplemental premium rates and total required revenue guarantees are limited to prescription drugs covered by the quoted formulary. Aetna reserves the right to adjust the level of the guaranteed increase per any request for formulary coverage expansion or enhancement. Unless specifically addressed in this document, all previously provided Financial Conditions also apply to this Medicare Advantage Renewal Guarantee.