Group Medicare Advantage Fact Sheet:

How Group Medicare Advantage Compares to Alternative Group Retiree Healthcare Options

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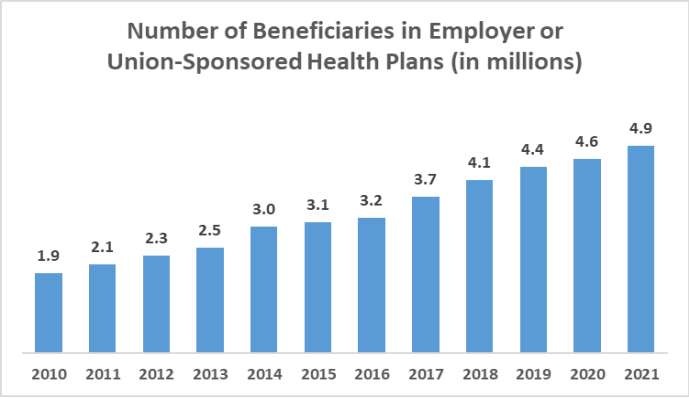
Plan sponsors in the United States have a variety of options from which to choose to provide healthcare coverage to their retirees. These options include coordinated plan sponsor-provided benefits which wrap around traditional Medicare benefits (often called "coordination of benefits" or COB), as well as Group Medicare Advantage (MA) plans which provide benefits that replace traditional Medicare altogether. Additional options include Group Medicare Supplement coverage, or providing retirees with a Health Reimbursement Arrangement (HRA) plan to purchase individual healthcare coverage. Plan sponsors must weigh a number of considerations when selecting the option which best meets their organizational goals.

While a small proportion of employers (27% of firms with over 200 employees in 2021[1]) offer retiree medical coverage, enrollment in Group MA has increased significantly over time. From 2010 to 2021, enrollment in Group MA plans increased by three million beneficiaries, or 260%.[1] This includes MA-only plans and MA plans with integrated Medicare Part D drug coverage (MA-PD plans). As of 2021, Group MA makes up nearly 20% of all MA enrollees.[1]

Figure 1



Source: KFF analysis of CMS Medicare Advantage Enrollment Files, 2010-2022

Group MA enrollment continues to rise in the U.S. retiree healthcare market for a variety of reasons.

For retirees, Group MA plans often provide similar or richer benefits, include supplemental benefits, and are generally easier for retirees to use compared to COB plans. In addition, Group MA plans use care management programs and provider networks as a means of generating savings. However, these items may be viewed by beneficiaries as limiting choice or creating administrative barriers.[2]

For plan sponsors, Group MA plans have historically mitigated cost trends compared to COB plans based on our analysis of financial results for public plan sponsors. The additional financial savings can be used to enhance retiree benefits, reduce retiree contributions, and reduce plan costs.

The subsequent sections in this paper further explore the landscape of group retiree healthcare options and the financial impacts for plan sponsors that have transitioned to a Group MA plan.

Coverage Options

There are a variety of options available for plan sponsors who offer healthcare coverage to retirees. The most prevalent retiree medical coverage strategies among plan sponsors include:

- Commercial Health Plan with Traditional Medicare Coordination of Benefits (COB) – The plan sponsor provides a self-insured group benefit plan which coordinates with Medicare.
- Group Medicare Supplement (Group MedSupp) – The plan sponsor provides supplemental coverage from a MedSupp carrier which offers enhanced coverage provided through Medicare Parts A and B ("Traditional Medicare") by reducing member cost sharing.
- Group Medicare Advantage (Group MA) – The plan sponsor provides comprehensive coverage through an insurance product which effectively replaces (and often enhances) the coverage provided through Traditional Medicare. Group MA is also known as Medicare Part C.
- Individual Medical Coverage through a Fixed-Allowance Health Reimbursement Arrangement (HRA) – The plan sponsor provides a fixed HRA or other account-based allowance to its retirees, which they can use to purchase individual Medicare coverage. Retirees can select from a number of options, including Individual MA and Individual MedSupp plans, with various plan designs available within these products. In some

[1] https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2021-enrollment-update-and-key-trends/

[2] https://www.ahip.org/wp-content/uploads/2016/02/High-Value-Provider-Networks-Issue-Paper-2014_07_01.final-pdf.pdf

cases, plan sponsors will also provide retirees with access to a private retiree health exchange to assist retirees in navigating benefit offerings in the Medicare marketplace. Finally, retirees can use the account to fund expenses not covered by Traditional Medicare.

These medical coverage options can then be paired with various pharmacy coverage options, including:

- Self-Insured Group Plan – The plan sponsor provides a self-insured group benefit plan for prescription drug coverage. Federal subsidies are often provided to the plan sponsor to offset retiree drug costs through the Retiree Drug Subsidy (RDS) program. While initially very popular, changes under the Patient Protection and Affordable Care Act of 2010 (ACA) have made these plans less cost-effective and thus less popular among plan sponsors over time.[3]
- Part D Employer Group Waiver Plan (EGWP) – The plan sponsor provides prescription drug coverage via a self-insured or fully-insured arrangement with an insurance carrier. These arrangements typically include a Medicare-funded component matching the standard Medicare Part D benefit, and a secondary "wrap" component further enhancing the benefit to the plan sponsor's desired level of retiree cost sharing. Group Part D EGWP plans can be offered on an integrated basis via a MA-PD plan or on a standalone basis via a Prescription Drug Plan (PDP).
- Individual Pharmacy coverage through a Fixed-Allowance Health Reimbursement Arrangement (HRA) – If a plan sponsor provides a fixed HRA or other account-based allowance to its retirees, these funds can be used to purchase Medicare Part D prescription drug coverage on the individual marketplace. This can either be on an integrated basis via an Individual MA-PD plan or on a standalone basis via an Individual PDP. However, Individual PDP coverage cannot be purchased alongside a separate MA policy (group or individual). Retirees purchasing PDP coverage on the individual marketplace must therefore obtain medical coverage through Traditional Medicare, a COB plan, and/or a MedSupp plan.

Benefit Richness for Medicare-Covered Services

Benefit plan design (e.g., deductibles, coinsurance, copays, out-of-pocket maximums, and in some cases additional covered services) is an important consideration in evaluating retiree healthcare options. A rich plan design will generally have low member cost sharing and/or more robust supplemental benefit coverage, whereas a lean plan design will generally have higher member cost sharing and fewer additional covered benefits.

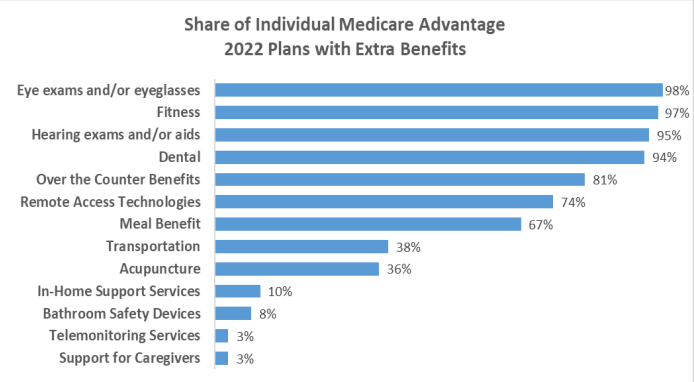
Plan sponsors have significant control over the "richness" of the benefits they offer to their retirees. Since plan sponsors are not required to offer health plans to their retirees in the U.S., those offering Group MedSupp, Group MA, and Traditional COB plans are typically doing so for other reasons, such as collective bargaining requirements, historical practice, or to attract and retain employees in a competitive industry. There can be significant differences in benefit plan design among these plan sponsors, but the retiree medical coverage provided through these products typically includes richer benefits than those available in individual plans.

Supplemental Benefits

Group MA plans aim to reduce costs relative to Traditional Medicare through coordinated care. The Centers for Medicare and Medicaid Services (CMS) requires a substantial portion of those savings be returned to beneficiaries in the form of reduced premiums and enhanced plan benefits, which can include additional / supplemental benefits not covered by Traditional Medicare.

Most Group MA and Individual MA plans offer additional / supplemental benefits. The table below shows that in the 2022 calendar year, over 90% of Individual MA plans offer vision, fitness, hearing, and/or dental benefits.[4] Group MA plans commonly offer these additional benefits, as well. However, there is no comprehensive public data for the additional benefits offered through Group MA plans.

Figure 2



Source: KFF analysis of CMS Landscape and Benefit files for 2022

[3] https://benistar.org/retiree-drug-subsidy-rds-vs-employer-group-waiver-plans-egwp/

[4] https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2021-premiums-cost-sharing-out-of-pocket-limits-and-supplemental-benefits/

In addition, as a result of regulatory changes in 2018 and 2019, CMS expanded the scope of supplemental benefits from being strictly health-related to including social needs benefits that support daily maintenance of health, especially for those with chronic conditions.[54] These benefits include, but are not limited to, transportation for non-medical needs, home safety modifications, pest control, and various counseling services.[6]

Since Traditional COB and MedSupp plans do not have the same incentives to provide supplemental benefits, these plans are less likely to provide them to the same extent as MA plans.

Access to Providers

Most, but not all providers, accept Traditional Medicare reimbursement as payment for covered services. For most Traditional COB and MedSupp plans, any provider that accepts Medicare reimbursement is generally included in the plan's network.

Plan sponsors and insurers have a variety of provider network options when offering MA coverage to retirees. The most common options are Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs). HMOs contract with specific providers and typically do not reimburse for services provided outside of that network. Similar to HMOs, PPOs have a network of providers who offer services at contracted rates, but unlike HMOs, PPOs still cover services provided by out-of-network providers. This out-of-network coverage may in some cases be associated with increased member cost sharing, though this is not always the case.

Individual MA plans do not have specific geographic requirements beyond ensuring the network of providers within the plan's service area provides sufficient access to Medicare-covered services for the population. Approximately 62% of all Individual MA members are enrolled in a HMO plan,[7] where the MA carrier is only required to cover services provided by in-network providers.

Unlike Individual MA plans, Group MA plans are not prohibited from enrolling members residing outside the plan's defined service area, subject to certain requirements around access to providers and in-network member cost sharing.[8] Depending on the group, retirees can reside in a wide geographic footprint, and it may be beneficial for a Group MA plan to be set up with limited network restrictions and a large panel of in-network and out-of-network providers. As a result, approximately 76% of Group MA members are enrolled in a PPO plan.[7]

Providers that accept Medicare must accept patients that have Traditional COB and MedSupp plans, but they are not required to accept patients with MA plans. In order to alleviate these restrictions, the majority of state-sponsored Group MA plans utilize a non-differential PPO benefit design which allows members to see both in and out of network providers and incur the same level of cost-sharing.[9] This design minimizes differences in provider access for some Group MA plans compared to Traditional COB and MedSupp options.

Member Experience

MA plans offer a coordinated member experience with one member ID card, call center, and benefit plan. This reduces the administrative burden of adhering to different policies, filling out paperwork, and remembering multiple online log-in IDs.[8]

The retiree's cost sharing obligation under a given MA plan is generally straightforward since it is adjudicated under a single plan design. Traditional COB and Medicare Supplement plans tend to be more complex, since these benefits wrap around standard Medicare benefits, which can make it more difficult to understand what a beneficiary may owe.

The CMS Star ratings program rates the quality of MA plans across multiple domains on a one-to-five scale. Examples of Star rating measures specific to the member experience include, but are not limited to:

- Call Center – Foreign Language Interpreter and TTY (Teletypewriter) Availability
- Customer Service
- Getting Appointments and Care Quickly
- Complaints about the Plan
- Plan Makes Timely Decisions about Appeals

The federal government promotes MA plan performance (as measured by Star ratings) through direct and indirect financial incentives. MA plans that meet certain quality-based measurements can achieve a higher Star rating, which in turn leads to higher payments from the federal government. High Star ratings can also lead to indirect benefits to MA plans, such as the ability to market to members year-round in the case of 5-star plans. This dynamic encourages MA plans to provide a positive member experience and to promote member engagement.

[5] https://bettermedicarealliance.org/wp-content/uploads/2021/11/Milliman-Issue-Brief-CY-2022-MA-Supplemental-Benefits_20211115112.pdf

[6] https://www.cms.gov/Medicare/Health-Plans/HealthPlansGenInfo/Downloads/Supplemental_Benefits_Chronically_Ill_HPMS_042419.pdf

[7] https://www.kff.org/medicare/fact-sheet/medicare-advantage/

[8] https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c09.pdf

[9] https://www.arkleg.state.ar.us/Calendars/Attachment?committee=045&agenda=4867&file=Exhibit+C+-+Final+Report_11182021-Attachment+A_Segal+Report_Final.pdf

Group MA Cost Analysis

To understand the financial impact for plan sponsors that transitioned from Traditional COB to Group MA, we reviewed historical trends and explored estimated cost impacts by utilizing publicly available information from public plan sponsors.

Exhibit 1 summarizes the historical premium trends for Group MA plans compared to historical claims cost trends for Traditional COB plans for several sample public plan sponsor groups. The representative groups in Exhibit 1 all provide post-employment benefits to eligible retirees and were selected based on the public availability of their claims cost information from 2017 to 2020.

Exhibit 1
Historical Trends for Public Group Retiree Healthcare Plans[1,2]

Group Type	Group Name	17-18	18-19	19-20	Annualized Trend
Group MA	Illinois State Plan	0%	2%	-13%	-4%
	State of Georgia	0%	6%	-23%	-7%
	Pennsylvania State	-28%	-7%	-21%	-19%
	North Carolina Base Plan	-1%	-8%	-2%	-4%
Traditional COB	North Carolina 70/30 Plan	-1%	-1%	11%	3%
	New York State Plan	7%	8%	N/A	8%
	State of Delaware Plan	0%	6%	-5%	0%

[1]Normalized for health insurer fee and plan design changes, when applicable.
[2]Group MA trends are based on premiums and Traditional COB plans are based on claims costs

As displayed in Exhibit 1, the Group MA plans studied experienced lower healthcare cost trends from 2017 to 2020 relative to Traditional COB plans. Annualized Group MA plan cost trends ranged between -4% and -19%, whereas annualized trends for Traditional COB plans ranged between 0% and 8%. The 2019-2020 period observed some of the lowest trends for Group MA. This is driven by a variety of factors such as price compression, improvements in care coordination, and Star ratings measures.

The lower trends observed for Group MA plans suggest these public plan sponsors have lower ongoing retiree healthcare costs compared to public plan sponsors with Traditional COB plans, which may result in greater financial flexibility for those plan sponsors who made the switch. This additional financial flexibility can be leveraged by plan sponsors to, for example, enhance retiree benefits, reduce retiree contributions, and/or pass through financial savings to taxpayers. This can be seen in public entities that transitioned from Traditional COB to Group MA in the last few years. Below, we highlight several specific Traditional COB to Group MA conversions.

State of Alabama Public Education Employees' Health Insurance Plan (AL PEEHIP)

In 2017, the State of Alabama Public Education Employees' Health Insurance Plan (AL PEEHIP) transitioned from a Traditional COB plan to a Group MA plan for all members. Exhibit 2 summarizes the historical savings for AL PEEHIP from transitioning from a Traditional COB plan to Group MA plan, using publicly available financial information and adjusted for changes to the plan design. Please see the Methodology section for the methodology utilized in these calculations.

Exhibit 2
AL PEEHIP - Cost Analysis - Conversion from Traditional COB to Group MA effective 1/1/2017[1]

Year	Enrolled Membership	Total Estimated Savings[2]	Per Member Per Month (PMPM) Estimated Savings[1,2]
2017	63,506	$34.5M - $47.3M	$43 - $62
2018	66,686	$33.0M - $61.1M	$41 - $76
2019	67,545	$36.7M - $81.1M	$45 - $100
2020	71,458	$37.0M - $102.1M	$43 - $119
2021	74,714	$102.1M - $190.7M	$114 - $213
Total		**$243.3M - $482.3M**	**$59 - $117**

[1]Normalized for plan design changes.
[2]Estimated claims savings based on differences between historical MA premiums and projected Traditional COB claims costs. Estimated savings range is developed by trending Traditional COB claims costs for the 2016 plan year to the projection year assuming 0% trend for the low end of the range and 8% trend for the high end

The results depicted in Exhibit 2 show significant financial savings each year after transitioning to a Group MA plan, resulting in an average savings of $59 to $117 per member per month from 2017 to 2021. In addition, after the transition to Group MA, the plan benefits were enhanced and retirees saw a reduction in primary care physician, specialist, and emergency room copays.

Missouri Consolidated Health Care Plan (MCHCP)

The Missouri Consolidated Health Care Plan (MCHCP) transitioned to a Group MA plan in 2019. Their annual report states MCHCP observed "a decrease of $217.4 million due to medical benefits for Medicare-eligible participants moving to a Medicare Advantage plan."[10] While MCHCP reduced plan benefits in 2019, which would have provided some savings, they reported that the substantial majority of the $217.4 million saved was not related to the benefit changes.

Further, MCHCP did not change the percentage-based retiree contribution formula when transitioning to Group MA. Since retiree contributions are based on a percentage of total costs, MCHCP retirees experienced a reduction in their retiree contributions from 2018-2019.[10,11]

State of Illinois

Financial statements from the State of Illinois tell a similar story. The State of Illinois added Group MA plans in 2014 and estimated savings of $58 million and $150 million in 2014 and

[10] http://www.mchcp.org/aboutUs/documents/annualReport_2019.pdf

[11] https://ia600709.us.archive.org/27/items/2018MCHCPAnnualReport/2018MCHCPAnnualReport.pdf

2015, respectively, due to members shifting towards Group MA. Rather than replacing the Traditional COB plans, the State of Illinois provided retirees with both Group MA and Traditional COB options and allowed retirees to select either plan.[12]

Similar to MCHCP, the State of Illinois did not change its percentage-based retiree contribution formula after adding the Group MA options. Since the Group MA options were lower cost compared to the Traditional COB options, this enabled the State of Illinois to pass along a portion of the savings from the Group MA plan to retirees in the form of reduced retiree contributions.

Based on these examples, it appears that Group MA plans can mitigate historical claims cost trends and provide savings to plan sponsors compared to Traditional COB arrangements. If realized, the cost trend mitigation can provide plan sponsors with additional financial flexibility that can be used to enhance retiree benefits, reduce retiree contributions, and/or pass through financial savings to taxpayers. The ultimate decision on how to deploy this additional financial flexibility is up to the plan sponsor.

Conclusion

Plan sponsors can provide healthcare benefits to retirees through a variety of methods, and each of these methods have their advantages and disadvantages. In summary, Group MA plans offer:

- ✓ Benefit designs that are typically richer than the individual market options
- ✓ Expanded access to supplemental benefits beyond traditional Medicare coordinated plans
- ✓ A more coordinated member experience compared to Traditional COB and Group MedSupp plans
- ✓ Greater financial flexibility that can be used to enhance retiree benefits, reduce retiree contributions, and/or pass financial savings on to taxpayers (as indicated by data from public plan sponsors who have transitioned to Group MA)
- – Potentially less access to providers compared to Traditional COB and Group MedSupp plans

These factors have all played a role in driving the growth in Group MA plans observed in recent years.

Methodology

Our methodology for this analysis involved examining publicly available Other Postemployment Benefits (OPEB) financial reports subject to Governmental Accounting Standards (GASB) 74/75, which establish financial disclosure requirements for government entities whose employees are provided retiree medical benefits. These required disclosures include an actuarial projection of per capita retiree costs, as well as plan designs. In performing our analysis, we relied on the post-age 65 per capita costs and premiums as well as plan design and enrollment in the OPEB reports. Historical trends for Group MA plans were developed based on premiums, and historical trends for Traditional COB plans were developed based on claim costs.

In selecting state groups for the analysis, we reviewed a sample of available OPEB statements on state websites for groups with Group MA and Traditional COB plans. While many states have published GASB statements available online, few provide complete information. Our selection of state groups for the analysis was independently determined based on the completeness of publicly information available.

Our trends and savings estimates were normalized for the impact of plan design changes during the respective time period for each group. We utilized the Milliman Health Cost Guidelines to develop plan design normalization factors.

GASB-specific citations used for Group Medicare Advantage Cost Analysis:

State of Illinois:

https://cgfa.ilga.gov/

State of Georgia:

https://shbp.georgia.gov/opeb-reports

Pennsylvania State:

https://www.budget.pa.gov/

State of North Carolina:

https://www.nc.gov/

Alabama PEEHIP:

rsa-al.gov

New York:

https://www.cs.ny.gov/

Delaware:

https://open.omb.delaware.gov/

[12] https://cgfa.ilga.gov/Upload/FY2015GroupInsuranceReport.pdf

Caveats, Qualifications, and Limitations

The authors of this report are employees of Milliman, Inc. Andrew Timcheck and Alex Zaid are actuaries for Milliman, members of the American Academy of Actuaries (AAA), and meet the qualification standards of the American Academy of Actuaries to perform the analysis supporting this report. To the best of their knowledge and belief, this information is complete and accurate and has been prepared in accordance with generally recognized and accepted actuarial principles and practices.

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Please note that in preparing our estimates, we relied upon public information from OPEB reports. Actual results will certainly vary for specific Medicare organizations and other stakeholders due to differences in trends, discount arrangements, formulary, utilization patterns, and rebate arrangements, among other factors.

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