Retiree Health Care—
Options for Your Participants

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Today's Agenda

- Ever-evolving Medicare health and pharmacy landscape
- Original Medicare A and B refresh
- Emergence of Medicare Part C—Medicare Advantage
- 2025 Medicare Advantage payment changes
- Group-sponsored Medicare prescription drug history
- Inflation Reduction Act (IRA) impact on union group plans
- Medicare benefit case studies
- What’s next in group Medicare benefits

Medicare Parts A, B, C and D

PART A
Inpatient Care
paid from Hospital Insurance Trust Fund

PART B
Outpatient Care
paid from Supplementary Medical Insurance Trust

PART C
Inpatient & Outpatient Care
funded from both sources

PART D
Prescription Drug
coverage program for Medicare beneficiaries

Medicare Parts A and B Background

- Original Medicare signed into law in 1965 to provide healthcare benefits for post-65 retired Americans—In 1972, extended to pre-65 disabled retirees
- Original Medicare consists of Two (2) primary parts:
  - **Part A Hospital:** Pays for in-patient hospital care; Free for Americans who worked and paid by payroll taxes
  - **Part B Medical:** Pays generally 80% of outpatient services and medical equipment
    - Retirees pay a standard monthly premium determined by Social Security

Medicare Coordination Benefits

$1,000 Medicare Allowed Expense

Medicare Pays Primary	Balance Due
80% (or $800)	20% (or $200)

- Self-funded coordination
- Medicare supplement/Medigap

Plan/Retiree Pay $200

Claims are processed by any provider who accepts Medicare, with no network restrictions or prior authorizations

Medicare Part C—Medicare Advantage

PART A
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paid from Hospital Insurance Trust Fund

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Outpatient Care
paid from Supplementary Medical Insurance Trust

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Evolution of Medicare Part C

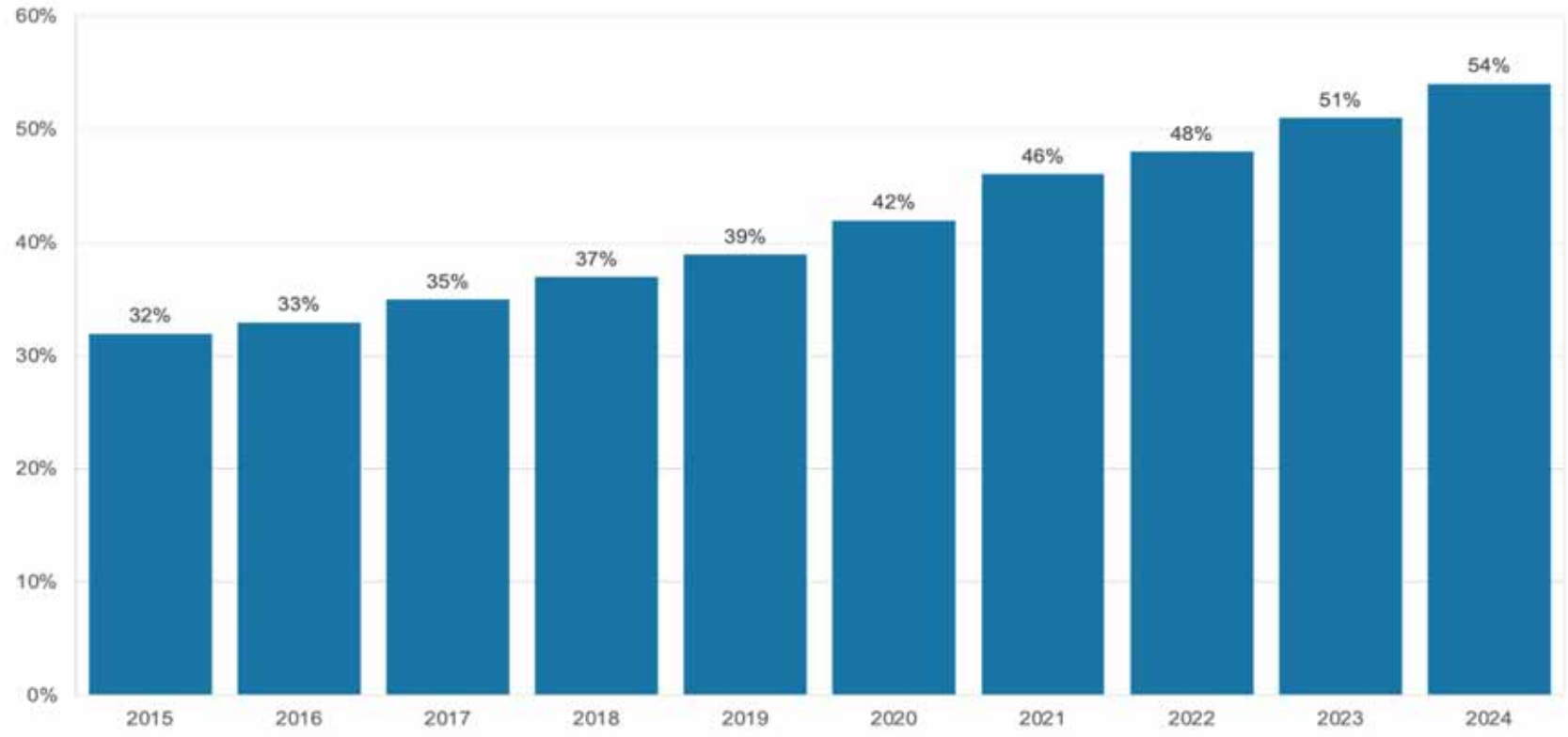
- Medicare Part C is an alternative to Original Medicare offered by private insurers that contract with CMS to provide Part A and B benefits—Retirees still pay monthly Part B premium. Plans can include non-Medicare services like vision, dental, hearing, fitness and others in an all-in-one, integrated program
  - 1997: First launched part of the Balance Budget Act (BBA) and initially called the Medicare+Choice Program
  - 2003: Passage of the Medicare Modernization Act (MMA) scrapped the Medicare Choice Program in attempt to revitalize Part C and renamed Medicare Advantage
  - 2005: CMS institutes the Star Rating (1–5 scale) to create metrics that encourage quality across all MA plans
  - 2006: Group MA + Part D (MAPD) plans become available on regional basis
  - 2010: MA carriers began offering national PPO networks to group sponsored plans that more closely matched original Medicare's participating providers

Medicare Advantage Pricing Process

Benchmark	CMS sets the Benchmark by region. This is the maximum amount CMS will pay per member for that region in 2024	$1,100 PMPM
Star Rating Bonus	4-star plans qualify for a 5% bonus, increasing the benchmark by $55 PMPM.	$1,155 PMPM
Capitation Bid	The carrier's estimate of the cost of providing Medicare services.	$1,100 PMPM
Risk Score Adjustment	The capitation bid is adjusted upward due to the risk score of 1.1 x $1,100 (bid) = $110	$1,210 PMPM
Premium Calculation	The difference between adjusted benchmark and adjusted capitation, $1,155–$1,210 = ($55 PMPM)	$55 PMPM Shortfall
Final Premium	The carrier passes the difference in the calculation shortfall to the client billed premium rate of $55 PMPM	**$55 PMPM Premium**

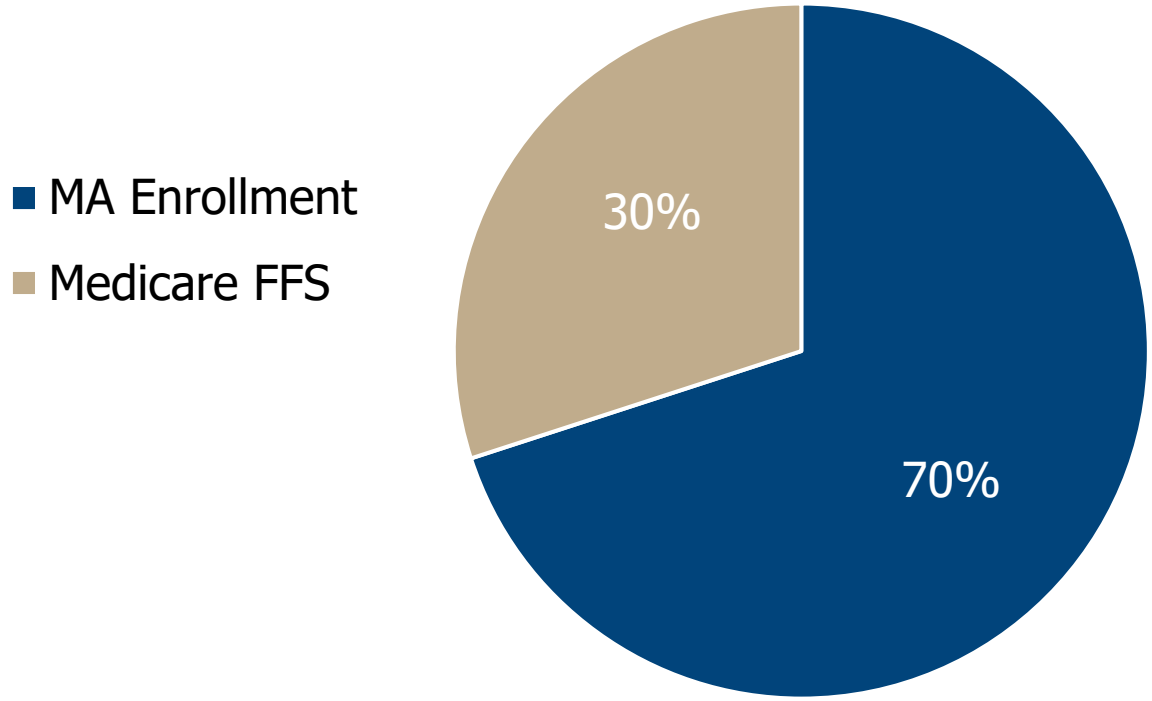
Medicare Advantage Growth

More than 32.8M (over 54%) of the 61.2M Medicare beneficiaries are enrolled in MA in 2024



Medicare Advantage Growth

Group-Sponsored Medicare Advantage Enrollment Increase



2025 MA Headwinds

- CMS made changes to ensure more accurate payments, promote quality in care and better manage Medicare spending.
  - Changes to the Risk Adjustment model—ICD9 to ICD10 coding changes resulted in reduction in payments for plans covering high-cost enrollees
  - Star Rating Adjustments—Adjustments to quality measures and star ratings, including higher emphasis on health outcomes and equity
  - CMS finalized an average payment increase of 3.7% for MA plans, notably lower than the range of 4-6% carriers anticipated to keep pace with rising costs, inflation and utilization trends
  - After risk score changes, factored MA payments cut by 0.16%
- Resulted in pricing headwinds on Medicare Advantage plans, due to changes not keeping up with rising costs and utilization trends in the marketplace.

Impact on MA Group Premiums

	2024	2025
CMS Region Benchmark	$1,100 PMPM	$1,137 PMPM
Adjusted Benchmark—4+ Star Bonus (5%)	$1,155 PMPM	$1,194 PMPM
Capitation bid	$1,100 PMPM	$1,235 PMPM
Risk Score adjustment	x1.10 = $110 PMPM	X1.05 = $61 PMPM
Adjusted Capitation Amount	$1,210 PMPM	$1,296 PMPM
Premium Calculation (Difference between adjusted benchmark and capitation)	($55) Shortfall	($102) Shortfall
Final Premium Billed	**$55 PMPM**	**$102 PMPM**

Disproportionate Impact on Union Plans

- 2025 Medicare Advantage payment changes had a larger impact on group union-sponsored compared with other segments of the MA marketplace
  - Group sponsored Union plans are often designed to provide enhanced health benefits and coverage to retirees
  - Union group plans often cover older retirees with more complex health needs, leading to higher average risk scores with non-union and individual MA enrollees
  - The changes to risk adjustment are designed to address perceived overpayments due to higher risk coding. Union plans often cover older retirees with more complex health needs are more reliant on these risk-adjusted payments.
  - Individual MA plans market can adapt to payment reductions through benefit design and cost-sharing adjustments. Different dynamic for union group plans

Medicare Part D Prescription Drug

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Group Medicare Prescription Evolution

- Medicare Part D was introduced through the Medicare Modernization Act of 2003, with coverage starting in 2006.
- Group union plans faced a choice: Offer group Part D as a stand-alone option or maintain their own plans and receive a Retiree Drug Subsidy (RDS).
- Majority initially opted for RDS to continue providing a seamless experience for retirees without shifting to Part D plans—RDS more administrative overhead
- While RDS helped unions continue offering their own retiree drug coverage, it did not address the rising costs of prescription drugs and subsidies were not tax free, which further reduced the financial benefits.

Group Medicare Prescription Evolution

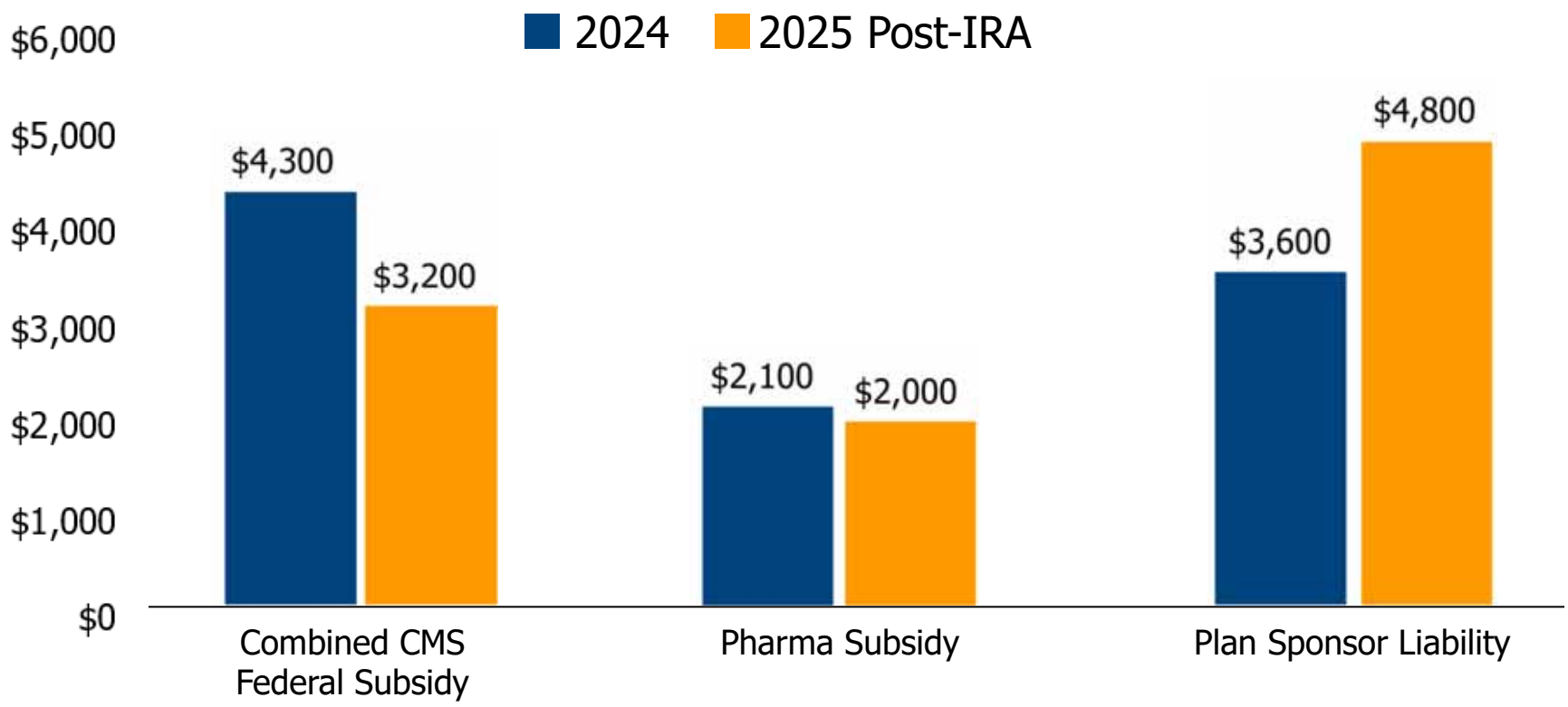
- Resulting from ACA in 2010, EGWP (Employer Group Waiver Plans) are plans designed specifically for group plans, offering tailored prescription drug benefits within a Medicare framework.
- More simplified compliance and administration alleviating the burden on the plan sponsor staff and professional overhead
- Enhanced financial subsidies, reinsurance and low-income subsidies from CMS, resulting in lower plan costs and improved OPEB liability management by transferring risk to the insurer
- The main driver of the shift was cost savings: EGWP group plans leveraged additional subsidies, resulted in savings that far outweigh RDS subsidy.

By 2024, this transition resulted in approximately 80–90% of group plans utilizing Group Part D EGWP instead of RDS

Inflation Reduction Act (IRA) Changes

- The primary goal of the Inflation Reduction Act (IRA) regarding Medicare Part D is to lower prescription drug costs for beneficiaries
  - Insulin cap: $35/month cap on insulin costs (effective 2023).
  - Free vaccines: No cost for vaccines under Part D (effective 2023).
  - Inflation rebates: Drugmakers pay rebates if prices rise faster than inflation.
  - Price Negotiation: Medicare can negotiate prices on high-cost drugs starting in 2026.
  - Major changes to Part D financial payment system and subsidy calculation
    - Out-of-Pocket Cap: $2K annual cap on out-of-pocket expenses by 2025
    - Donut Hole Elimination: No more coverage gap by 2025.

IRA Subsidy Changes Shifting Liability Example

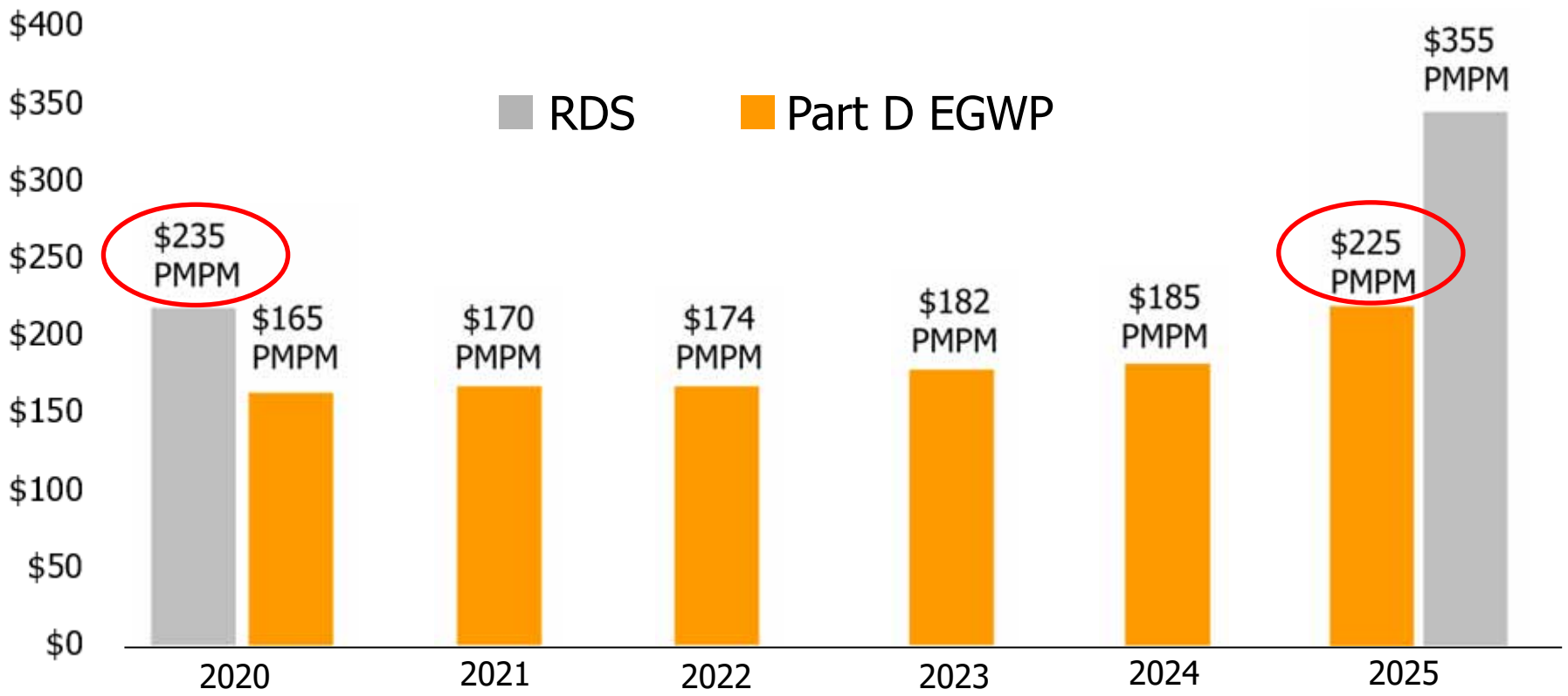


Negative Impact to Group Union Plans

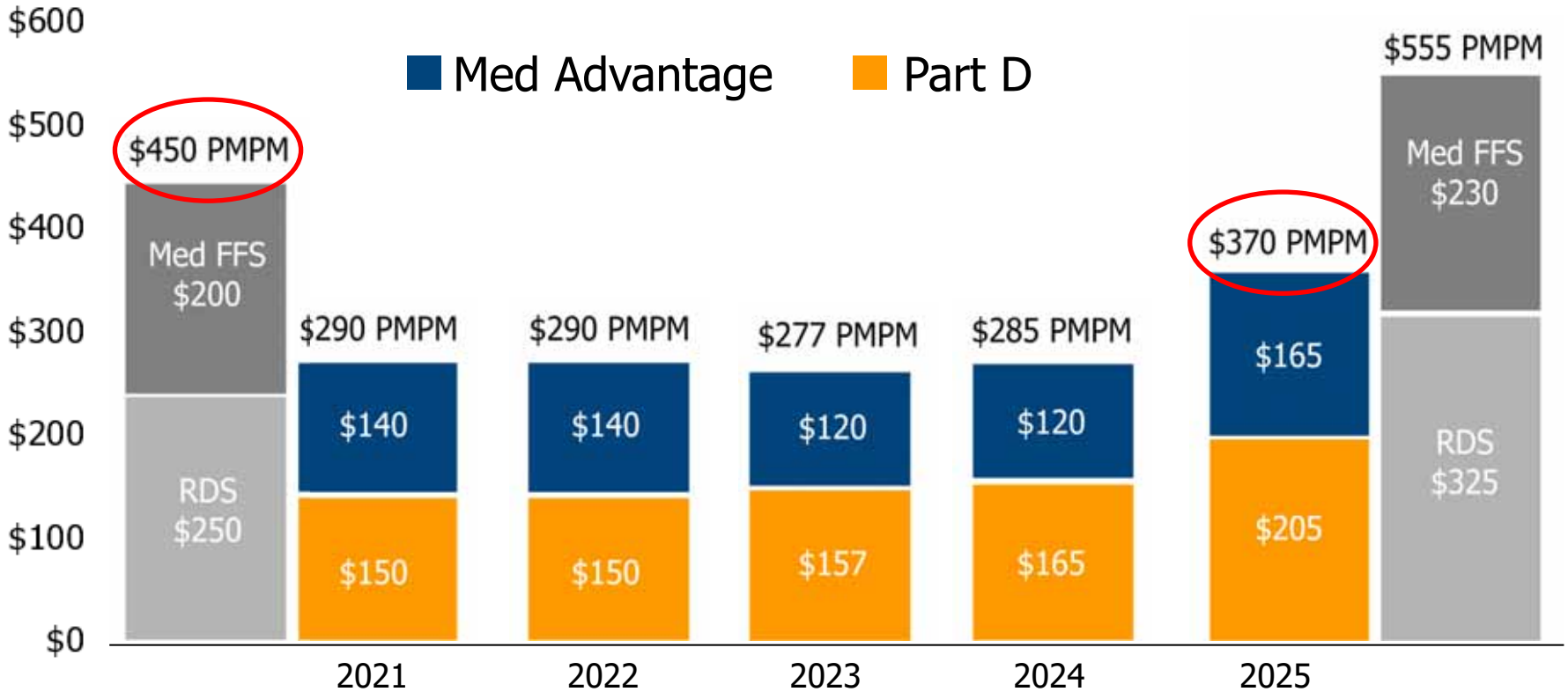
- The legislative intent behind the IRA was primarily focused on protecting individual Medicare beneficiaries rather than plan sponsors like union group health plans.
  - Unintended consequence of shifting costs to plan sponsors, including union group health plans, occurred because of these broader policy goals
  - Additional administrative and compliance costs due to IRA-driven regulatory changes, adding strain to plan management
  - The assumption is that plan sponsors, as larger entities, have the flexibility to adapt to these changes or absorb cost increases, whereas individual retirees would benefit immediately from the financial relief.

Case Studies

Case Study—Group Part D Rate History



Case Study—MAPD Rate History



Where Do We Go From Here?

- Part D prescription drug outlook
  - Price shock is one and done
  - Liability has been shifted more on Plan Sponsors
  - EGWP Part D still best option vs RDS alternative (IRA further diminished RDS value)
  - Will IRA achieve its goals and objectives still unknown?

Where Do We Go From Here?

- Medicare Advantage headwinds and future
  - Quality benefits customized more than traditional Medicare
  - Financials still better vs. original Medicare coordination
  - What will Phase 3 of payment changes bring?
  - Recent MA provider network pushback needs to be monitored

Questions?

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Session Evaluation