Navigating Group Retiree Healthcare: *Latest Insights for Consultants*

As a broker or consultant, we understand your commitment to providing the best service to your clients. That's why we are here to support you with our specialized expertise in group retiree healthcare, market intelligence, and service models. We do not compete with you; instead, we complement and support your efforts as an extension of your organization.

We understand that your primary focus may lie elsewhere in your book of business. That's why we offer our specialized expertise in group retiree healthcare, allowing you to leverage our knowledge and provide comprehensive solutions to your clients.

Insight #1

The Medicare landscape is changing and will continue to change. Here are the key drivers, which are translating into cost pressures.

Key Overall Changes

In general, healthcare costs have grown at a rate faster than inflation.

- The demographics of Medicare beneficiaries and Medicare-eligible individuals are skewing older[1]
  - From 2020 to 2030, seniors aged 75 to 79, 80 to 84, and 85 and older are projected to grow as a proportion of all seniors. This is a shift from the 2015–20 period, when growth was more heavily in the cohort aged 65 to 74[2].
- Higher claims experience tied to higher utilization of healthcare services[3]
- Overall increase in utilization both on the medical and pharmacy side especially with the growing demand for newer medications[4]
- Plan design changes as more healthcare services are being covered

Key Regulatory Changes

- MA Rates
  - Despite an overall increase in payment, the impact to MA rates was the first decline since 2015 and averages a loss of $150 per member per year to the payers.[5] In addition, CMS made a reduction in calculations related to indirect and direct medical education costs associated with services provided to MA enrollees which will apply to years 2024 through 2026.

Key Regulatory Changes (continued)

- Annual CMS changes to Part D that include Threshold/TrOOP and rebate share changes as CMS enhances and restructures the benefit
  - These changes typically focus on the member out-of-pocket, financial contributions from manufacturers, and financial contributions from the health plans[6]
- Risk Adjustment—CMS payment to the health plans based on the health status of their membership
  - A couple of significant changes include:
    - Stricter criteria on how to code a claim for payment
    - Removal of some codes from the risk adjustment model
- Health plan will receive less money from CMS to manage the sicker members which will potentially drive an increase in premiums
- Star Ratings Changes
  - Changes include new measures, removal of measures and technical changes that may make it harder to get a high Star rating
- Member maximum out-of-pocket change as a result of the Inflation Reduction Act
  - CMS has not yet released clear guidance on how plans will support the max out-of-pocket change for members from $8,000 in 2024 to $2,000 in 2025
  - Based on initial information, it appears that Medicare will contribute less, and health plans will need to contribute more to the max out-of-pocket change; the overall impact is unknown at this time[7]

What to Consider as a Result

- You may see rate conservatism with the carriers in 2024 in preparation for the unknowns in 2025
- Carriers may be more reticent to provide rate locks and multi-year guarantees
- Carriers are more selective in new bids
- You may see MA/MAPD premium increases and PDP premium increases in mid-single digits due to the changes from CMS and the Inflation Reduction Act
- Keep a close eye on your client's renewal bids. Your clients may have seen flat or decreases in renewals, however due to changes and increases in environmental, external, and regulatory pressures, premiums are increasing.

Insight #2

Medicare Advantage (MA) and Medicare Advantage Prescription Drug (MAPD) enrollment is growing rapidly, particularly in group retiree plans. As economic pressures mount and group retiree healthcare plan coverage faces potential cutbacks or discontinuation, MA can offer cost-saving opportunities that enable employers to continue providing plans and lower OPEB liabilities.

What to Consider as a Result

- Medicare Advantage (MA) and Medicare Advantage Prescription Drug (MAPD) plans offer valuable benefits for plan sponsors and retirees when designed properly and supported adequately. It's important to conduct thorough research and due diligence to ensure the best fit based on your clients' retiree population's unique characteristics and needs.
- Transitioning retirees into a new plan requires careful consideration and hands-on support. At RetireeFirst, we proactively engage retirees with high-touch communications such as in-person meetings with printed handouts, educational webinars, simple webpages, and clear letters that avoid jargon.

- Given that Medicare Advantage operates on a different model, plan sponsors can play a pivotal role in helping retirees understand the plan, its rules, and network. According to the latest Fierce Healthcare article, the biggest potential friction points with Medicare Advantage enrollees are misinterpretation of plan benefits, overbilling concerns, confusion about plan features, and navigating prior authorizations. These potential areas of friction need to be strategically addressed in order to effectively overcome them.[8]
- Transitioning to a Medicare Advantage plan allows retirees to retain the coverage they require while often enjoying supplementary benefits not provided by other Medicare-eligible employer-sponsored plans. These additional benefits can encompass broader provider networks, flexibility of prior authorizations, reduced copays, extended medication supplies, and ancillary benefits.

Insight #3

If your client is considering a private Exchange option to move their retirees into individual Medicare plans, usually driven by the desire to reduce costs or alleviate the day-to-day administration of retiree healthcare plans, there are group options to consider. These alternatives can accomplish the same outcomes while offering retiree advocacy, nurturing the company's positive relationship with retirees, who often serve as the most vocal and public critics.

What to Consider as a Result

- A group alternative can be designed to include various benefit and carrier options, equivalent or better costs, direct retiree billing, improved benefit coverage, lower copays, and broader network access—like what's often found in a group plan. This alternative can also incorporate HRA funding and is supported by strong member advocacy, which is not typically part of the Exchange.

Sources

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8. Fierce Healthcare "Majority of Medicare Advantage enrollees don't fully understand their plan" https://www.fiercehealthcare.com/payers/majority-medicare-advantage-enrollees-dont-fully-understand-their-plan

At RetireeFirst, we can collaborate with you and your client to design the best approach. Our sole focus on retiree benefits means our solutions, combined with our people-centric approach, deliver immediate savings, lighten the administrative workload of servicing retirees, and help preserve the benefits retirees deserve. Our unparalleled retiree advocacy service connects members to programs that help improve their health and wellness, resulting in happier and more engaged members.

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