Comparing Group Medicare Advantage Plans and Private Medicare Exchanges

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Employers and other sponsors of group health plans that cover retirees are looking for ways to reduce costs—on both a cash and retiree medical liability basis—and provide more value to retirees. Both of those goals can be achieved for retirees over age 65 through two popular approaches: group Medicare Advantage (MA) plans and private Medicare exchanges.

This article provides an overview of both approaches. They each offer unique and very different value propositions to plan sponsors and retirees. We compare their strengths and weaknesses from the perspective of both stakeholders. The goal is to help plan sponsors decide which approach may be more appropriate as a retiree medical strategy for their post-65 retirees.

What Are Group Medicare Advantage Plans?

Group MA plans combine benefits covered through traditional Medicare (Part A and Part B[1]) and additional benefits offered by a plan sponsor through coordination of benefits (COB) into one plan. Group MA plans can, and typically do, include Medicare Part D pharmacy benefits. Alternatively, pharmacy benefits may be provided separately through a self-insured group plan.

Group MA plans, which are offered by private insurers, provide senior-centric coordination and management of clinical care. Programs include wellness and prevention, acute illnesses, chronic conditions, advanced illnesses and end-of-life care. Clinical and customer service teams within these programs help participants effectively manage their health care needs and navigate the health care system. This level of support and coordination of care creates cost savings and can improve the participant experience while providing the same level of benefits or better. This is in contrast to COB with traditional Medicare, in which health management is often limited or nonexistent.

To subsidize the cost of MA plan coverage, insurers receive monthly per person payments from the Centers for Medicare & Medicaid Services (CMS). The goal is that CMS pays the MA plan an amount similar to what it costs them under the fee-for-service program. Those payments are based on geographic area of residence and an individual risk score for each plan participant. The better the insurance companies are at managing risk scores,

AT A GLANCE

- Group Medicare Advantage (MA) plans and Medicare exchanges offer unique and very different value propositions to plan sponsors and retirees.
- Both options can reduce plan sponsor costs. Plan sponsors have more control over group MA plans, but Medicare exchanges provide retirees with more choices.
- Several considerations may help determine which approach is most appropriate for a particular plan sponsor. A successful transition depends on vendor capabilities, the time allowed to make the change and well-thought-out retiree communications.

the greater the payment they receive from CMS. This is achieved primarily through medical coding accuracy, ensuring all the diagnoses of a patient are collected, thereby capturing each participant's true health risk. The payments are also based on the insurer's CMS Five-Star Quality Rating for the plan, with greater payments to plans with higher ratings based on quality measures (e.g., clinical measures, member experience and medication adherence). Insurers charge premiums to plan sponsors to cover the cost of benefits and enhancements above what Medicare provides.

What Is a Private Medicare Exchange?

A *private Medicare exchange* is a marketplace owned and operated by a company or nonprofit organization where Medicare beneficiaries can purchase individual coverage available in their area.[2] Options typically include Medicare supplemental coverage (more commonly known as *medigap* plans), MA plans and prescription drug (Part D) plans. The number of choices and rates may vary depending on who owns the exchange (as each exchange itself has some form of uniqueness); where retirees live; and, for Medigap plans, the age, gender and smoking status of retirees.

Information about the coverage options and the premium amounts is available on each exchange vendor's website. To help retirees select the plan that best meets their specific medical and prescription drug needs, exchange vendors provide high-touch call center support. That guidance is supplemented by web tools. Once retirees are in an exchange, the vendor provides customer support and advocacy services for life.

To offset the cost of coverage on a Medicare exchange, plan sponsors typically—but are not required to—give retirees a defined contribution through a health reimbursement arrangement (HRA) plan that's often administered by the exchange.[3] Through the HRA, retirees are reimbursed tax-free for health care costs, whether it be for premiums or out-of-pocket expenses. Of course, these are limited by the available funding the plan sponsor provides.

Who Determines the Plan Design?

In a group MA plan, the plan sponsor generally controls the design.[4] Typically, the plan sponsor is able to offer benefits that match the current plan design but at lower costs. If the MA plan includes prescription drug coverage, the plan sponsor generally has more control over which drugs are on the formulary.

An important note is that individual Part D plans cannot be provided alongside an MA plan, since CMS will not allow enrollment in two separate plans concurrently. Therefore, if the plan sponsor does not provide any prescription drug coverage, a group MA plan cannot be offered.

For exchange plans, the insurers control the plan design, and retirees can select from an array of options, including prescription drug coverage, since the existing group plan is eliminated. Coverage is often significantly different from the sponsor's prior group coverage and varies geographically. In the individual market, formularies and pharmacy networks tend to be more restrictive than the ones in group plans. Medigap coverage is generally standardized nationally, with a menu of choices available.[5]

The plan sponsor also controls the design of the HRA plan, including how account balances may be used: only to pay premiums or also for out-of-pocket costs. Even more importantly, the plan sponsor also controls how much it puts into the HRA to pay for everything. Some plan sponsors also provide a supplemental HRA to help retirees with any catastrophic prescription drug costs.

How Do the Cost Savings Compare?

For plan sponsors that move their coverage for Medicare-eligible retirees from traditional Medicare to a group MA plan, it's not unusual to see a significant reduction in premiums. The reduction will vary depending on geography, demographics and the size of the group. If retirees share in premium costs, they will benefit from that premium reduction.

The MA premium reduction comes from increases in revenue and decreases in claims cost, both of which are managed by the insurer. Increases in revenue are achieved through two sources. The first source is based on the plan's CMS Five-Star Quality rating. Those plans with a rating of at least four stars receive payments that are approximately 5% higher than a plan with

a 3½ star rating. The second source is to choose an insurer that has robust Medicare risk-adjustment (MRA) capabilities. Payment for each participant in an MA plan is based on a documented risk score, which is developed from diagnosis coding on medical claims. MA insurers with robust MRA capabilities are able to maximize risk scores through multiple programs to make sure all diagnoses are accurately coded to reflect the member's true health risk. Decreases in claims cost are achieved through multiple clinical care management programs designed to better manage member health. Given the high prevalence of chronic conditions within the population, focused geriatric-specific programs can have huge financial implications. These same programs are not typically provided in group COB coverage, where it is not cost-effective to invest in managing claims when Medicare is paying the majority of the cost.

When transitioning coverage to a Medicare exchange, the cost savings for a plan sponsor is determined by the HRA contribution level. In most cases, that subsidy can be set below the current levels, while providing enough funding for equivalent or improved value to retirees. Sometimes the greatest benefit to sponsors can be in managing the cost escalation.

The size of the risk pool in a Medicare exchange makes the cost of insurance competitive compared to traditional coverage for smaller groups that coordinate with Medicare and results in more stable premium rate increases. Typically, at least 95% of retirees who obtain coverage from a Medicare exchange will see savings on a total out-of-pocket cost basis, if the subsidy is appropriate. For most participants, relative to costs under their current plan, higher plan utilization costs (e.g., deductible and copayments) are more than offset by lower individual market premiums. The savings will vary from individual to individual, based on their specific needs and plan choice. While younger and healthier retirees can see significant savings, older retirees or those with high prescription drug spending may see cost increases.[6] For example, many states allow age rating of individual Medigap policies, which could mean attractive individual rates at age 65 but less competitive rates as seniors age. Medicare prohibits age rating of all Medicare Advantage policies.

When comparing the potential cost savings, an important additional consideration is whether costs are variable or fixed. As group plans, MA plans are subject to annual renewals. This means the plan sponsor's costs may vary year over year (positively or negatively) unless the employer subsidy is capped (i.e., does not increase with trend).

When coverage is moved to a Medicare exchange, the plan sponsor's cost is fixed through the HRA contribution (making this a defined contribution health care plan for the plan sponsor). Some plan sponsors implement tiered contributions that vary according to criteria like years of service or family status. These amounts can be kept flat or increase with a cost-of-living adjustment (COLA) to help offset a portion of premium increases, at the sole discretion of the plan sponsor. That means the plan sponsor is in control of whether its costs will increase and by how much.

How Does the Value to Retirees Compare?

Retirees, who tend to have longstanding relationships with their health care providers, care about their coverage network. Moreover, retirees, especially those who typically take more than one prescription medication, are very interested in which drugs are on formularies.

Group MA plans can be either health maintenance organizations (HMOs) or preferred provider organizations (PPOs). If 51% of a PPO group's membership lives in the MA plan's network service area, the plan is able to offer the same level of benefits regardless of whether a retiree uses an in-network or out-of-network provider. This is known as a "passive" PPO, and beneficiaries may see virtually any provider that accepts Medicare. This allows for broad coverage across the country, and therefore is the type of MA plan most groups elect to provide for their retirees. It is very common to meet the 51% rule and implement the passive network instead of the HMO option.

Retirees appreciate the typically broad formularies available to group MA plans that compare favorably to the formulary in their prior group plan. They also like the fact that there is no individual underwriting (because MA plans receive revenue from CMS based on each member's individual risk score).

From the retirees' perspective, a possible disadvantage of a group MA plan is the fact that they have no choice about coverage or cost-sharing alternatives. It would be up to the plan sponsor to offer additional plan options. For example, plan sponsors may offer an HMO and a PPO or a couple of plan designs with premium differentials, if the group is large enough. Note that with the passive PPO, a retiree could see any provider that accepts Medicare, so the choice above is primarily focused on plan design features such as copayments and deductibles.

For retirees, the choice available in a Medicare exchange is a strong selling point. Medicare exchanges offer a large number of plan options for individual coverage. Those coverage options include national Medigap plans or local MA plans that are usually HMOs. There can be significant savings for retirees who choose exchange coverage because Medigap premiums vary by age and state, and Medigap plans and local MA plans offer varying coverage levels. Regardless of the coverage option selected, retirees may elect to purchase coverage that costs them more ("buy-up") or less ("buy-down"). Provider networks are very important in the selection, if members decide to choose the lower-cost HMOs. Unlike the active health insurance market where the individual market is less robust, the Medicare private health insurance market is thriving and stable for individual policyholders.

For some retirees, the more restrictive prescription drug formularies in the individual market may be less attractive than a traditional group plan. In addition, while Medigap plans are guaranteed renewable, some states allow for underwriting for retirees who are looking to switch to a new Medigap plan after the initial transition. However, underwriting does not apply (i.e., plans are guaranteed issue) to Medigap plans when transitioning from the group plan, for renewals in Medigap plans, or for individual Medicare Advantage or prescription drug (Part D) plans.[7]

Retirees tend to appreciate the fact that their HRA account balances can typically roll over from year to year. That allows younger and healthier retirees to save their HRA money until later in retirement when their need for health services is likely to be greater. Naturally, this is not as much of a benefit for older retirees.

What About Other Variables That Matter to Plan Sponsors?

Plan sponsors may also be interested in comparing these aspects of the two alternatives:

- Plan administration
- Vendor relationship
- Compliance.

MA plans are fully insured, which means the insurer performs most aspects of plan administration, including enrollment and reporting through CMS, medical management, member services and communications. However, because the plan sponsor is still providing group coverage, it remains responsible for some aspects of plan administration, such as communicating eligibility/enrollment rules, benefit plans and premium rates to retirees as well as fielding their questions.

In contrast, under a Medicare exchange, the exchange vendor is responsible for all aspects of plan administration, including HRA administration. Vendors have call centers to assist retirees. This represents a significant reduction in the administrative burden for plan sponsors, freeing staff to focus on other HR priorities.

When retirees are moved to a group MA plan, the plan sponsor only partners with the vendor chosen to cover their members. That makes it easy to address certain member issues that arise. Moreover, when all retirees are in one plan, the sponsor has a strong position when negotiating renewals.

In a Medicare exchange, the vendor addresses any issues that arise about the retirees' coverage. To cover administrative costs, a commission for each retiree is part of the individual market premium. This means the plan sponsor generally has no direct costs outside of funding the HRA.

When sponsors in the private sector transition their group coverage for Medicare-eligible retirees to a Medicare exchange, the HRA is still governed by the Employee Retirement Income Security Act of 1974 (ERISA). Group MA plans are governed by CMS as an Employer Group Waiver Plan (EGWP). EGWPs are MA and Part D plans customized for groups by applying certain modifications or "waivers" to MA/Part D requirements originally developed for individual plans. The

TABLE

Comparing Group Medicare Advantage (MA) Plans With Private Medicare Exchanges

	Group Medicare Advantage (MA) Plan	Private Medicare Exchange
Cost savings to the plan sponsor	Based on premiums and current group plan claims experience	Determined by the health reimbursement arrangement (HRA) contribution
Fixed vs. variable costs for the plan sponsor	Typically variable	Fixed (unless the plan sponsor chooses to provide a cost-of-living adjustment (COLA) by increasing its HRA contribution)
Cost savings to retirees	Based on premiums and contribution structure	Based on individual needs and plan choice as well as the funding provided by sponsor
Plan type/networks	Typically national passive preferred provider organization (PPO) with or without a prescription drug plan. The PPO would provide a broad network.	National medigap coverage or local MA plan health maintenance organization (HMO)/PPO and prescription drug plan. The HMO may have a restricted network.
Control of plan design	Typically plan sponsor	Insurer
Formulary control and scope	Typically plan sponsor; tends to be broad	Insurer; tends to be narrow
Plan choice for retirees	Typically one to three options	Many options
Individual underwriting	None	Possible for a medigap coverage after initial transition and age-rating schedules
Plan administration	Shared between insurer and plan sponsor	Exchange vendor
Insurer relationship	Ongoing	Minimal
Retiree communications	Shared between insurer and plan sponsor	Exchange vendor
Enrollment support	Plan sponsor responsibility if more than one plan is offered	Provided by exchange vendor

waivers provide regulatory flexibilities for group plans so that they can participate in the MA/Part D markets. Many people think of EGWPs as Part D prescription drug plans only, but they actually refer to both MA and Part D plans that are group plans.

What Else Should Plan Sponsors Consider When Comparing Both Options?

The accompanying table summarizes the key features of group MA plans and Medicare exchanges discussed above. There are other considerations that may help plan sponsors determine which approach is most appropriate based on their unique goals and their retiree population.

These are among the most common additional considerations: plan sponsor control vs. retiree plan choice, procurement requirements and legislated benefits/collective bargaining.

For some plan sponsors, group plan control carries considerable weight in deciding whether to change post-65 retiree coverage and, if so, which choice to make. As noted

earlier, the plan sponsor retains control over the design and structure of a group MA plan.

By contrast, a Medicare exchange is a market approach where "one size fits all" no longer applies. Retirees are responsible for choosing the plan that best meets their needs. The exchange vendor, not the plan sponsor, is available to help retirees make a choice.

For plan sponsors that have procurement requirements on a periodic basis (e.g., every three to five years), Medicare non-solicitation rules can make moving from an existing Medicare exchange vendor challenging. The non-solicitation rules mean a new exchange vendor is often unable (or reluctant) to provide advice to retirees who are already in the individual market or to help them change coverage. Consequently, after having moved retirees to a Medicare exchange, a plan sponsor that is interested in covering retirees through a different Medicare exchange would likely need to make that switch for future retirees only. Having not yet been in an exchange, future retirees would not be subject to Medicare non-solicitation rules. This type of restriction is not an issue with MA plans.

For groups that have benefits that are legislated or collectively bargained as well as for grandfathered populations, a transition to a private Medicare exchange could be more challenging. Although the chance of a lawsuit exists with any potential plan change, there is greater risk associated with moving to a private Medicare exchange than a group MA plan, since the group plan is eliminated and the benefit design would likely vary. That is an advantage with the group MA plan, where the design can largely be matched. These risks should be vetted with legal counsel prior to any potential transition.

What Are the Critical Factors in a Successful Transition?

Plan sponsors that decide to change how they provide coverage to Medicare-eligible retirees need to be aware of several factors that can ensure successful transition—or derail it. They are:

- Vendor capabilities
- Time
- Retiree communications.

In transitioning to an MA plan, it is important to choose an insurer with a proven track record and years of experience dedicated to this product. MA is governed by CMS with highly complex requirements and oversight. An insurer with MA expertise in all areas of operations is critical to ensure viability for the plan.

In transitioning to a Medicare exchange, it is important to ensure that the HRA vendor handles the administration of accounts appropriately. Late payments or incorrect payments can cause confusion and potentially sabotage the success of the transition. It is also important for the plan sponsor to be committed to the HRA funding level or amount. When it is all said and done, this amount is instrumental in keeping the premiums affordable to the retiree.

It is essential to leave enough time for the transition. A successful MA implementation will take at least six months. Depending on the size of the retiree population, a Medicare exchange vendor may need to staff up to service the population. Typically, transitioning to a Medicare exchange requires an implementation time frame of six to nine months, but the process of vendor selection, subsidy development, and internal and external socialization can often take a year or more.

Well-thought-out retiree communications are a critical component of a smooth transition. CMS requires a tremendous amount of communications to be provided by the MA vendor. Additionally, a good MA vendor will typically provide retiree education meetings on behalf of the plan sponsor. If coverage is being moved to a Medicare exchange, detailed communications in multiple formats are essential to ensure retirees understand decision-making and payment processes as well as what will be expected of them. Major changes tend to cause anxiety. Holding retiree meetings, if practical, can help quell any fears retirees may have. Most private Medicare exchange vendors provide some level of communications support to aid in the transition. But for plan sponsors that require more customized communications support, vendor communications alone may not be sufficient to help retirees at the level the plan sponsor believes is necessary.

What Has Been the Experience of Plan Sponsors That Made a Transition?

Over the years, we have worked with many plan sponsors on transitioning their post-65 retirees to either a group MA plan or a private Medicare exchange. Regardless of the choice, they experienced significant savings on both a cash basis and a retiree medical liability basis.

Equally important, the transitions were made without diminishing retiree satisfaction. Communication about the change in coverage overcame initial trepidation.

Based on that experience, plan sponsors can decide to make a transition with confidence. Which approach to choose depends on the factors that are most important to you. BQ

Endnotes

1. Part A pays for inpatient hospital, skilled nursing facility, hospice and certain home health care services. Part B covers physician services, outpatient hospital services, certain home health services, durable medical equipment and other items.
2. Some exchanges also offer services to retirees who are not yet eligible for Medicare. Others offer group coverage alongside individual market coverage.
3. The health reimbursement arrangement (HRA) must be a retiree-only plan. It cannot be available to active employees.
4. Some states have requirements for standardized plans.
5. Medigap plans differ from other states in Massachusetts, Minnesota and Wisconsin.
6. The plan sponsor can consider establishing a catastrophic coverage program for retirees who must pay more for coverage under a private Medicare exchange.
7. State-specific Medicare information, including details about medigap rules in California, Connecticut, Maine, Massachusetts, Missouri, New York, Oregon and Washington, is available on healthinsurance.org.

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