The Current State of Group Medicare Benefits

Presented by:
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Labor First / Retiree First
Most Plans relied on tax revenue & investment returns to fund costs of retiree health benefits annually and never accounted for the future financial liability of providing those benefits “Pay As You Go”
The State of Post-Retirement Health Benefits

Years of economic and demographic changes have threatened the sustainability of providing post-retirement health benefits

› Health care costs rising faster than inflation – U.S pharmacy trend magnified

› Shifting Retiree vs. Active participants ratio – Aging membership

Today, the Actuarial value to provide post-retirement health benefits (Other Post-Employment Benefits “OPEB”) has exceeded Pension estimated at over $1 Trillion nationally
The State of Post-Retirement Health Benefits

Years of economic and demographic changes have threatened the sustainability of providing post-retirement health benefits

› Health care costs rising faster than inflation – U.S pharmacy trend magnified
  › Shifting Retiree vs. Active participants ratio – Aging membership

Future problems and complications will only increase OPEB liability and continue to stretch benefit contributions to the limit

› Post-COVID impact could result in higher rates of late stage cancer diagnosis for seniors due to the drop-off in early screening and preventive visits
› Silver Tsunami (Baby Boomers aging into Medicare) – Over the next 25 years, retirees age 65+ are projected to increase by 67% compared to 16% growth for active workers age 24-54

Retirees age 85+ are projected spike by 189% over that same time frame
As an alternative to the Health Exchange model, many group sponsored plans have started to evaluate carving-out Medicare retiree benefits and providing coverage separate from their active working participants.

- Reduced plan costs and OPEB liability—fixed PMPM premiums can help future accounting
- Group designed benefits and premium pricing not available to the individual market along with the ability to offer options without the confusion of an Exchange
The Move Away from RDS to EGWP Part D

When the Part D prescription benefit was launched in 2006, plans providing Rx benefits to Medicare-eligible retirees were encouraged to continue this coverage by participating in either the RDS or EGWP programs.

Both RDS and EGWP allow plans to receive federal subsidies in exchange for providing prescription drug coverage that meet the minimal Part D coverage requirements.

The ACA has made EGWP the more attractive option by providing additional financial subsidies not available with RDS.

- Pharmaceutical Coverage Gap Discount
- Catastrophic Coverage Stage Subsidy

› Under GASB accounting rules, subsidies from RDS programs are considered general revenue that cannot be included as a reduction to costs when calculating the OPEB liability.

› By contrast, the GASB allows future subsidies from the EGWP program to factor into liability calculations, resulting in lower OPEB compared with RDS.
Medicare Advantage Plans are a type of Medicare health plan offered by a private company that contracts with Medicare to provide all your Part A and Part B benefits.

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<thead>
<tr>
<th>MA-Only</th>
<th>MA-PD</th>
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<tr>
<td>just medical coverage</td>
<td>medical and Part D Benefits</td>
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- Carriers receive additional reimbursement payments above the base Medicare fee schedule for plans that have a CMS quality rating of four (4) or more stars (1 to 5 scale)
- Plan sponsors pay carriers a set per member per month (PMPM) premium amount, calculated by each group’s benefit level and retiree demographics
- Increased reimbursements have resulted in declining premiums the last 5 years – CMS noted MA premiums were 6% lower in 2019

The number enrolled in Medicare Advantage plans has tripled since 2007 to 19 million
The Emergence of Medicare Advantage

![Bar chart showing the comparison between Medicare Advantage and Part D Prescription numbers in millions from 2010 to 2019. The chart indicates a steady increase in Medicare Advantage enrollment, with numbers ranging from 1 million in 2010 to over 4 million in 2019. Part D Prescription numbers also show growth, although at a slower rate.](chart.png)

*KFF analysis of CMS 2006-2018 Medicare enrollment data
SITUATIONAL OVERVIEW:
This municipal group of 631 Medicare participants located in New Jersey saved 25% of their plan costs converting from a self-funded RDS drug benefit to an insured EGWP Part D drug benefit with Labor First.

KEY HIGHLIGHTS:
• Transitioned from a Self-Funded RDS plan with Express Scripts to a Fully-Insured Express Scripts EGWP Part D Plan.
• Emulated the clients in-force plan design, keeping the overall benefit like-to-like for retirees.
• Members enjoyed the same singular ID card functionality utilized under their prior self-funded arrangement.
• A client since 2016, renewal increases are averaging 2.65% annually.
• Retiree Member satisfaction surveys indicate a current benefit and service rating of 9.6 out of 10!

RESULTS SUMMARY:

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<th>Benefit Plan Design:</th>
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<tr>
<td>Generic Drugs</td>
<td>20%, Min $5 to Max $50</td>
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<tr>
<td>Preferred Brand Drugs</td>
<td>20%, Min $20 to Max $50</td>
</tr>
<tr>
<td>Non-Preferred Brand Drugs</td>
<td>20%, Min $35 to Max $50</td>
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<tr>
<td>Specialty Drugs</td>
<td>$35</td>
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In-Force Cost Analysis:
- Pharmacy (Self-Funded) Net Annual Cost: $1,799,637.24
- Average Participants: 631
- Per Member Per Month RDS Cost: $237.67 PMPM

Labor First Proposed Costs:
- Per Member Per Month EGWP Cost: $188.59 PMPM
- Average Participants: 631
- Pharmacy (EGWP) Annual Cost: $1,428,003.48

Savings PMPM: $49.08
Total Monthly Savings: $30,969.48
Total Annual Savings: $371,633.76
Percentage Savings: 25%
SITUATIONAL OVERVIEW:
This municipality group of 13,000 Medicare participants located in Maryland. Entity was facing bankruptcy and therefore elimination of the current benefit structure within 5 years if no changes were made. We were tasked with finding and implementing a solution that reduced in force costs and OPEB without sacrificing member benefits.

KEY HIGHLIGHTS:
- Aimed to keep groups plan designs as close as possible to what they were currently in while also adding alternative benefit options to elect into.
- Enabled the Municipality to reduce their OPEB by over 30% and $515 Million
- Designed an implementation strategy that satisfied both the County as well as the three subgroups within.
- Able to secure multiple year rate concessions to assist with the transition.

Case Study: Medicare Retiree Carve-Out Program OPEB Liability Reduction

RESULTS SUMMARY:
- Client was facing having to eliminate the benefit within 5 years.
- Financial strategy was to set a fixed dollar contribution and keeping that contribution flat into the future. This strategy has enabled the Municipality to reduce their OPEB by over 30% and $515 Million (per Client Actuary)
- Client was currently self funding their Medicare Supplement and Part D EGWP Plans at an average monthly costs of $393 PMPM
- Performed a market analysis and found that a High, Medium, Low Medicare Advantage with Prescription Drug (MAPD) strategy would enable the Municipality to reduce their PMPM by $60 - $160 PMPM
- Offered the membership a high ( emulation of in force plan), medium, and low plan options. Providing the retirees choice of both a plan and premium cost share ranging from $100 down to $0 PMPM depending on their plan selection
If you or your fund professionals have questions or would like more information, please never hesitate to contact us.

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Cumulative Increases in Health Insurance Premiums, Workers’ Contributions to Premiums, Inflation, and Workers’ Earnings, 1999-2015
The average price of Humira in the United States is about 96% higher than in the United Kingdom.

Average price Humira, 1 prefilled syringe carton, 2 syringes, 28 day supply, 2014
Medicare Population Demographic Shift

Active Working Participants vs. Post-65 Retiree Ratio

Number of Non-Retired Participants for every 1 Medicare Retiree

*CMS 2019 Medicare Trustees Report*