GUIDE

Is a Group Medicare Advantage Program the Right Solution for My Retirement Health Benefit Plan?

With recent legislative changes to Medicare, combined with heightened scrutiny of Medicare Advantage plans, group plan sponsors have an even bigger challenge of choosing the right retiree benefits solution.

At RetireeFirst, we stay informed about evolving regulations and nuances of the group Medicare market. We guide plan sponsors, in partnership with their brokers or consultants, through various Medicare strategies and carrier options toward the best solution. Medicare Advantage (MA) or Medicare Advantage Prescription Drug (MAPD) is often the right strategy for group plan sponsors and their members, but there are important considerations and effective approaches to implementing these plans and successfully transitioning retirees.

This guide provides information to consider on Group Medicare Advantage plans, addresses potential issues, and offers a Retiree Benefits Management solution for a seamless transition.

Facts About Medicare Advantage

Similar Coverage

Plans must cover all medically necessary services that Original Medicare covers. Plans may also offer some extra benefits that Original Medicare doesn't cover—like certain vision, hearing, and dental services.[1]

31M+ Enrollees

More than half (over 31 million) of eligible Medicare beneficiaries are enrolled in Medicare Advantage as of 2023.[2]

95% Satisfaction

The Better Medicare Alliance's *State of Medicare Advantage 2023 Report* found that 95% of Medicare Advantage beneficiaries are satisfied with their coverage.[2]

1 in 5 in a Group Plan

One in five (about 5.4 million) Medicare Advantage enrollees are in a group plan offered to retirees by an employer or union.[3]

What can moving to or continuing a Group Medicare Advantage plan mean for you and your retirees?

- Reduced costs and OPEB liabilities for plan sponsors
- Lower costs for your retirees
- Enhanced benefits
- Integrated and coordinated care
- Focus on health and wellness
- Better health outcomes and fewer avoidable hospitalizations[4]

Medicare Advantage Supports Primary and Preventative Care

Medicare Advantage beneficiaries have higher rates of preventive screening measures like vaccinations and depression screenings.

49%
higher rate of receiving pneumonia vaccine compared to FFS beneficiaries[2]

11%
higher rate of receiving a flu vaccine compared to FFS beneficiaries[2]

19%
higher rate of depression screenings and follow-up planning[2]

Beneficiaries in Medicare Advantage also have lower hospitalization rates and more follow-up care.

43%
lower rate of avoidable hospitalizations for any condition[2]

21%
higher rate of seeing a physician within 14 days of a hospital discharge[2]

Lower rates
of inpatient utilization and emergency room visits for those with certain chronic conditions, including diabetes, hyperlipidemia, and hypertension[2]

What are some of the concerns being expressed around Medicare Advantage plans and what are the facts?

If you are concerned about denial of care, delayed care, or prior authorizations...

Prior authorization is a tool intended to ensure the beneficiary gets the right care at the right time.[5] According to a recent article in *The Wall Street Journal*, carriers are working on reducing prior authorizations and are trying to streamline the processes for getting answers to both the medical requests and appeals after denials.[6] In April 2023, the Biden administration released new, stricter prior authorization rules to help Medicare Advantage beneficiaries.[7]

In addition, on January 17, 2024, CMS finalized the CMS Interoperability and Prior Authorization Final Rule to improve the electronic exchange of health information and prior authorization processes. There are multiple components and varying timelines for all of the various sections of this rule. The scope of this rule includes application to Medicare Advantage organizations.

Prior Authorization Enhancements

- Beginning primarily in 2026, impacted payers will be required to send prior authorization decisions within 72 hours for expedited (i.e., urgent) requests and seven calendar days for standard (i.e., non-urgent) requests for medical items and services[8]
- The rule also requires all impacted payers to include a specific reason for denying a prior authorization request, which will help facilitate resubmission of the request or an appeal when needed[8]
- Payers will be required to publicly report prior authorization metrics, similar to the metrics Medicare FFS already makes available[9]
- Implementation of a new API process and system enhancements to facilitate a more efficient electronic prior authorization process between providers and payers by automating the end-to-end prior authorization process, something that Medicare FFS has already implemented[8]
- Patient access, Provider access, and Payer-to-Payer access to prior authorization information (excluding drugs) through an API process is required to be implemented by 1/1/2027[8]

If your concern is that providers will not be in network...

Group MA/MAPD plans can have very broad networks, including the option of utilizing a passive PPO network. In this context, individuals can often see any provider who participates in Medicare and accepts Medicare payments, even if they are technically out of network. Providers who are not contracted with a National MA PPO plan can still receive the same healthcare reimbursements as traditional Medicare based on the CMS Physicians Services Schedule. It's important to note that while most providers accept Medicare reimbursement, they are not obligated to accept Medicare Advantage patients, so there can be situations where a plan member's doctor won't accept reimbursement. This is where it is important to run and analyze a network disruption report and weigh the impact, if any, of disruption with the other benefits of moving to an MA/MAPD plan. A retiree benefits management specialist is equipped to help outreach to providers out-of-network to get them to accept the MA plan.

If your concern is about excessive carrier profits and overbilling...

CMS exercises strict oversight of Medicare Advantage organizations and their profits. For example, one requirement is that "Medicare Advantage gain/loss margins as a percent of revenue must be within 1.5 percent of the Medicare Advantage Organization's (MAO) non-Medicare business margin requirement."[10]

"Not only are profits controlled and monitored, and beneficiaries' out-of-pocket cost limited with an annual cap, but Medicare Advantage also offers more benefits and care coordination, targeting care and services to those with chronic conditions—and at roughly the same cost to government as traditional Medicare. Medicare Advantage continues to be highly preferred among Medicare beneficiaries, owing to the better quality it provides and the consumer cost protections it offers. Policymakers should be wary of false conclusions that undermine the care and benefits offered in Medicare Advantage, as well as valuable lessons for the future of Medicare."[10]

Another example of CMS's oversight is their continued focus on rigorous audits of Medicare Advantage plans and their performance through their yearly audit review process.

If your concern is about limiting your members to more of a managed plan from a Coordination of Benefits (COB) or a Medicare Supplement plan...

Consider offering a choice, examining what contributions would be for each plan. If you decide to move to an MA/MAPD program, consider having an advocacy partner on your side. With dedicated support, any potential issues can be effectively addressed, ensuring a smoother transition and optimal outcomes for both you and your members.

If your concern is about all the Medicare changes and the Inflation Reduction Act...

Consider partnering with RetireeFirst. The environment is changing quickly. We can help plan sponsors (along with their broker or consultant) think through the strategy, find the best carrier match to achieve your financial goals, and proactively address member issues before they escalate. We ensure a seamless transition for both plan sponsors and retirees, acting as the bridge to savings and enhancing the retiree experience. With partnerships extending to all national Medicare carriers, many regional carriers, and close collaboration with brokers and consultants, RetireeFirst is committed to driving savings, increasing member satisfaction, and helping to preserve retiree benefits.

RetireeFirst Client Testimonial

"Dealing with change can be tough, especially when it comes to retiree benefits. In 2019, we transitioned from Medicare Supplement to a MAPD plan. When we first joined forces with RetireeFirst, retirees were skeptical about the changes and worried about their benefits. But the way RetireeFirst handled the transition was impressive. They didn't just roll out the new plan; they came down to meet us in person. These meetings eased the retirees' concerns as we educated them about their benefits, assured them that they weren't going away, and let them know that the new MAPD plan was an enhancement."

—Joey Lopez
Director of Human Resources for the City of Baytown

To learn more,

visit RetireeFirst.com or contact sales@RetireeFirst.com to speak with one of our advisors.

SOURCES

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