B.2

State of Arkansas

Medicare Advantage and Part D Employer Group Waiver Plans (EGWP)

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Introductory Meeting and Preliminary Analysis

Segal

Medicare Advantage

Medicare ABCs

Medicare has four parts:

1	**Part A**	IP Hospital Services
2	**Part B**	Physician Services & OP Care
3	**Part C**	Medicare Advantage
4	**Part D**	Outpatient Prescription Drugs

- Medicare is administered by the Centers for Medicare & Medicaid Services (CMS), which in turn contracts with:
  - Administrators – Fee For Service (FFS) Parts A & B => Original Medicare
  - Private Health Plans – Part C
  - Prescription Drug Plans – Part D

Current Coverage for Medicare Retirees

- Employers typically provide supplemental insurance that may pay deductibles, co-insurance or other costs not covered by Original Medicare (wrap benefits, COB, med supp)
- Coordination of benefits:
  - **Full Coordination of Benefits (Full COB):** The health plan pays the difference between total eligible charges and the Medicare reimbursement amount, or the amount it would have paid in the absence of Medicare, if less
  - **Exclusion:** The health plan applies its normal reimbursement formula to the amount remaining after Medicare reimbursements have been deducted from total eligible charges.
  - **Carve-Out:** The health plan applies its normal reimbursement formula to the total eligible charges, and then subtracts the amount of Medicare reimbursement.

ASE and PSE have Full Coordination of Benefits.
This is the most expensive type COB for the Plan.

Group Medicare Advantage PPO vs. Original Medicare coordinated plans

Traditional approach

Medicare:
Pays primary

Supplement:
Pays secondary

(No coordination of care)

Group Medicare Advantage PPO

Incentives for health and wellness

Proactive closure of gaps in care

Coordinated care and support

The value of coordinated care under a single MA plan

Provider collaboration and incentives

Annual in-home appointments

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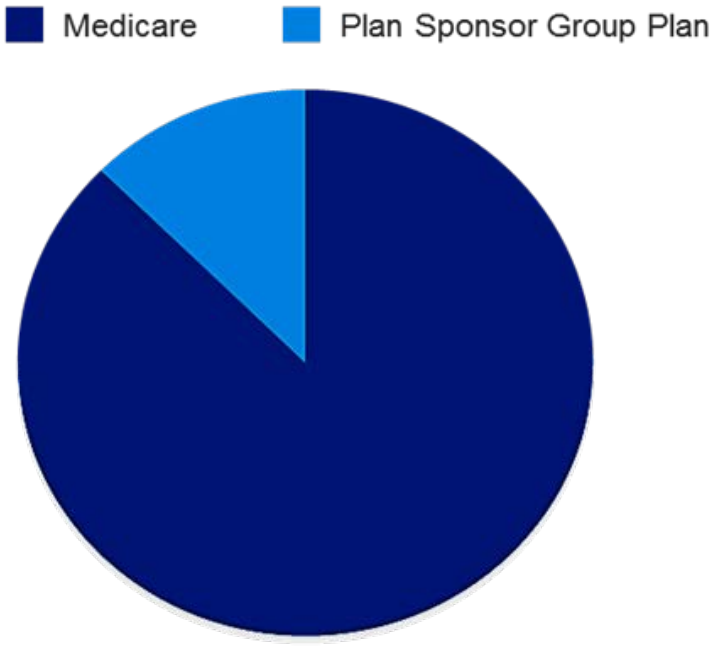
Why Group Medicare Advantage is More Cost Effective

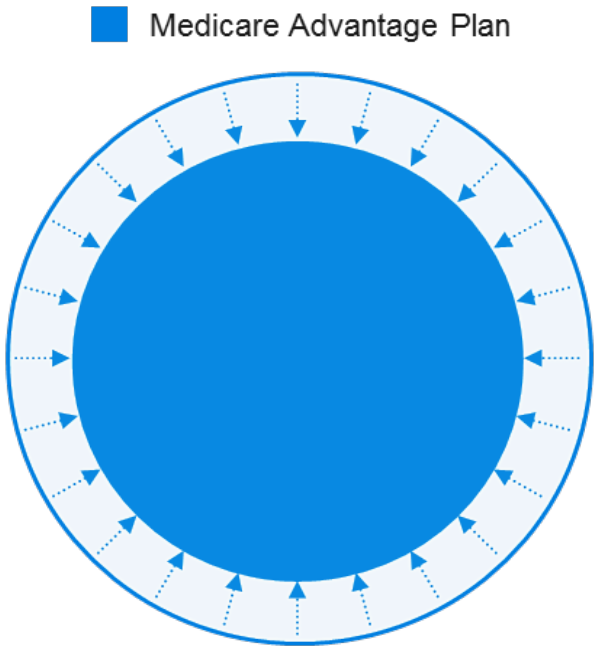
Medicare + Supplemental Plan



Typically Medicare pays 80% or more of the cost of services. The balance is paid by the Medicare Supplemental plan and possibly the retiree

With only 20% of the claim liability, it is not cost effective to invest in managing claims to reduce the size of the circle

Group Medicare Advantage



In a Medicare Advantage plan, the plan is responsible for the entire claim liability. The plan is also rewarded for Stars bonuses and reimbursed for risk adjustment accuracy

With the full claim liability, programs to better manage member health, while reducing the size of the circle, become cost-effective

Medicare Advantage Overview

- A Medicare Advantage (MA) Plan is offered by Private Carriers
- MA combines all benefits into one plan including:
  - Traditional Medicare (Parts A&B)
  - Wrap Benefits
  - Pharmacy (Part D) may be included in the same plan, but can be separate
- MA carriers receive capitated payments from CMS that subsidize the cost of coverage
- CMS provides payment based on:
  - **Benchmark Rates – fixed monthly payments based on county of residence**
  - **Risk-adjustment – reflects illness burden of each member**
- Fully insured premiums from Plan Sponsors to MA carriers cover the cost of benefits and enhancements above CMS payment
- MA carriers manage all claims, risk adjustment, clinical programs, care management and customer service

Medicare Advantage Key Dates

- 1997 – Medicare+Choice introduced (Balanced Budget Act)

- 2006 – Changed Medicare+Choice to Medicare Advantage (Medicare Modernization Act)
  - Increased the types of employer-sponsored plans that could contract and coordinate with Medicare by providing for “employer group waiver plans” or “EGWPs”

- 2011 – Changed payments to MA Plans to reflect Star Ratings (Affordable Care Act)
  - Phased in over 6 years
  - Added Health Insurer Fee (HIF)

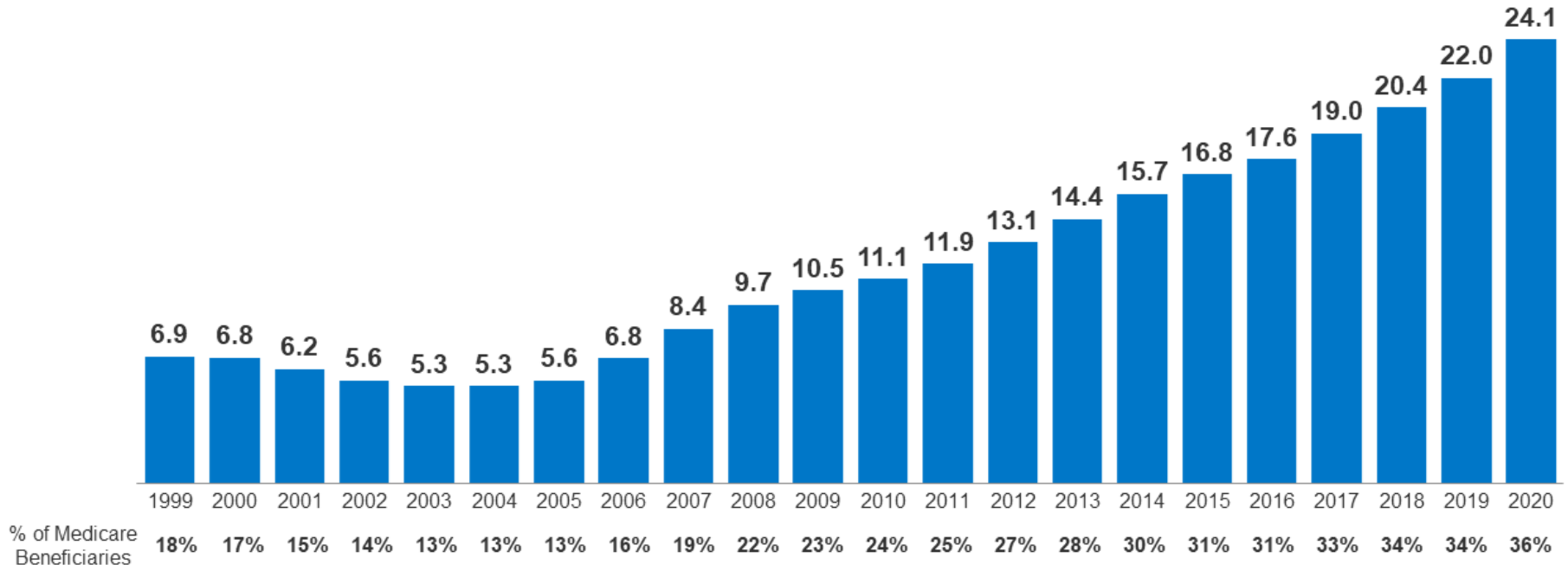
- 2017 – Changed EGWP bidding process from submitting group level bids to relying exclusively on the individual market bid process
  - Phased in over 3 years

- 2019 – HIF repealed for plan years beginning 2021 (Consolidated Appropriations Act)

Total Enrollment

Figure 1

Total Medicare Advantage Enrollment, 1999-2020 (in millions)



NOTE: Includes cost plans as well as Medicare Advantage plans. About 68 million people are enrolled in Medicare in 2020.

SOURCE: KFF analysis of CMS Medicare Advantage Enrollment Files, 2008-2020, and MPR, 1999-2007; enrollment numbers from March of the respective year, with the exception of 2006, which is from April.

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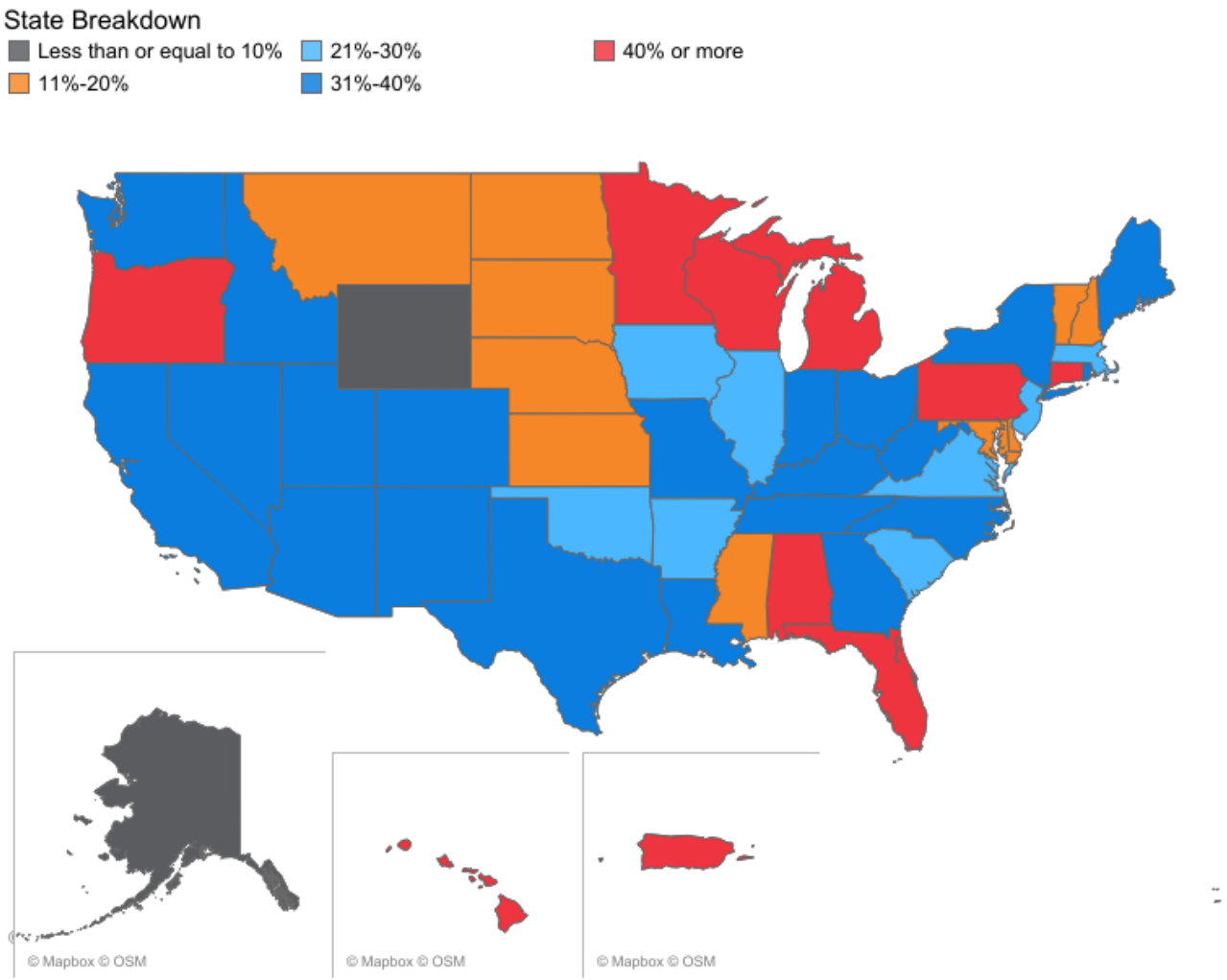
Segal

Medicare Advantage Penetration, by State, 2020

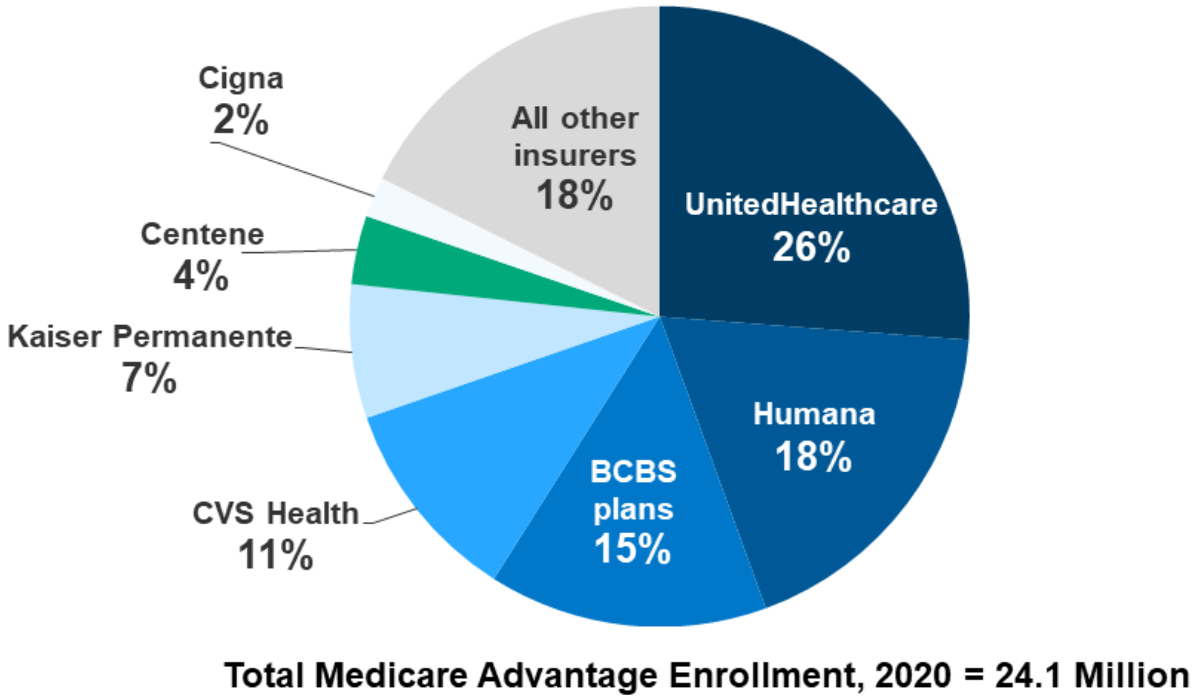


NOTE: Includes cost plans, as well as other Medicare Advantage plans. Excludes beneficiaries with unknown county addresses.
SOURCE: KFF analysis of CMS State/County Market Penetration Files, 2020.

Enrollment by Carrier

Figure 4

Medicare Advantage Enrollment by Firm or Affiliate, 2020



Total Medicare Advantage Enrollment, 2020 = 24.1 Million

NOTE: All other insurers includes firms with less than 2% of total enrollment. BCBS are BlueCross and BlueShield affiliates and includes Anthem BCBS plans. Anthem non-BCBS plans are less than 2% of total enrollment. Percentages may not sum to 100% due to rounding.

SOURCE: KFF analysis of CMS Medicare Advantage Enrollment Files, 2020.

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What is Group Medicare Advantage?

	Individual Medicare Advantage	Historical Group Medicare Advantage	Group Medicare Advantage PPO
Geographic availability	Limited to areas with viable contracted networks		National service area including all U.S. counties
Plan type	Primarily HMO		Non-differential PPO
Provider access	Contracted providers only		All willing Medicare providers
Financial value proposition	Typically higher retiree out of pocket costs	Actuarial equivalent benefits at lower cost	Actuarial equivalent benefits at lower cost
Sustainability	Significant market disruption followed Balance Budget Act of 1998		Nearly a decade of price stability and significant plan sponsor savings

What is a Passive PPO?

- Retirees pay the same cost share for services received both In-Network and Out-of-Network
- Carriers pay in-network providers according to their contracts
- Carriers pay out-of-network providers according to the Medicare fee schedule
- All Medicare accepting providers are provided with easy to use tools and resources to submit claims directly to the Carrier
- If the provider will not bill the Carrier, the member can pay the provider and submit a claim for reimbursement
- No PCP selection required, no referrals required to see a specialist

CMS allows Employer Group Plans to provide coverage to members anywhere in the country as long as they meet the network adequacy requirements for at least 51% of a particular employer or union group's beneficiaries.

Benefits to Members

A simpler experience

- No confusing coordination of benefits
- Single ID card
- One plan
- Single call center
- Single EOB

Equivalent design

- Equivalent benefit design
- Copayment based design
- Passive PPO
- Near universal provider access

Improved health and wellness

- Home visits
- Wellness programs
- Clinical programs
- Coordinated care

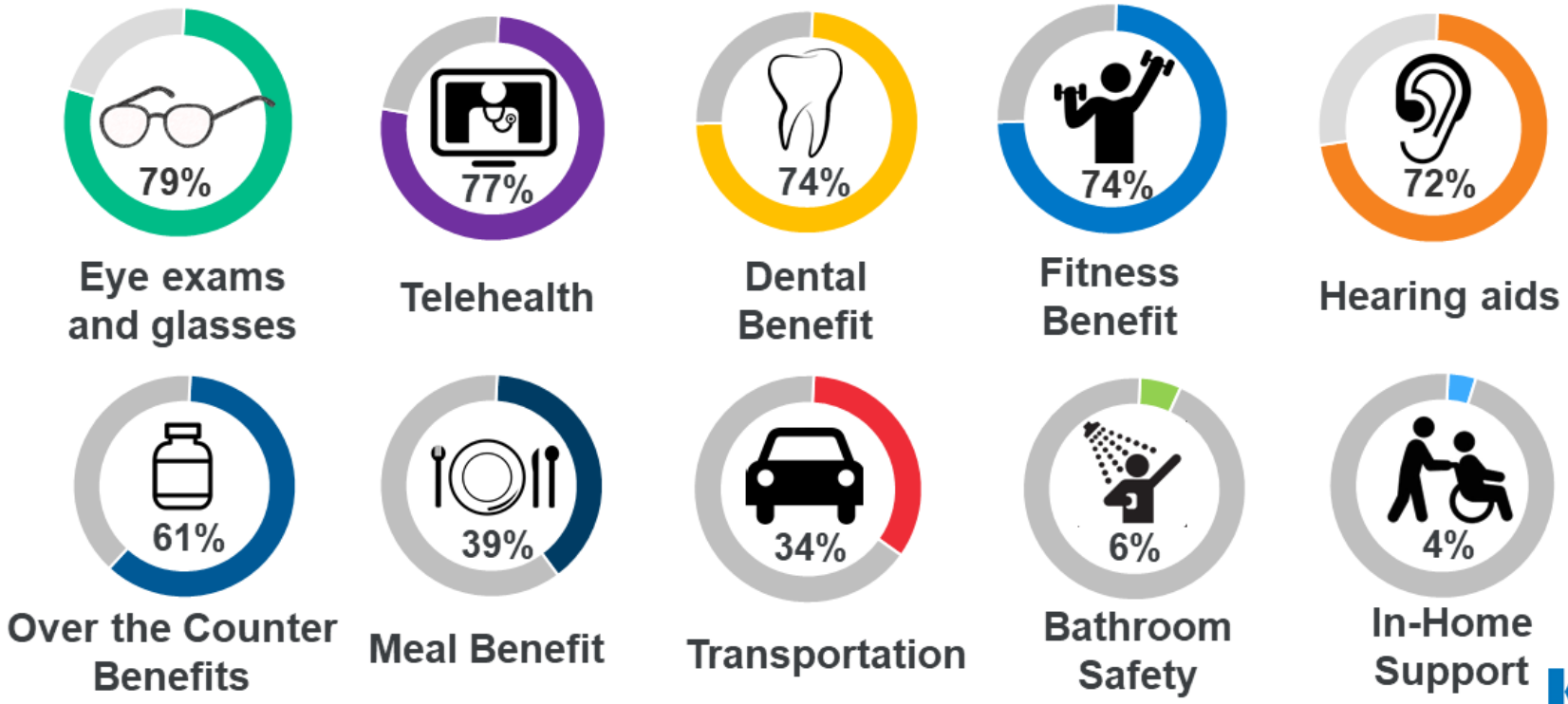
Additional benefits

- Meal delivery, non emergent transportation
- Wellness incentives
- Fitness benefit
- Hearing and vision coverage

Extra Benefits in 2020

Figure 9

Share of Medicare Advantage Enrollees in Plans with Extra Benefits by Benefit Type, 2020



NOTE: Dental includes plans that only provide preventive benefits, such as cleanings.
SOURCE: KFF analysis of CMS Medicare Advantage Enrollment and Benefit Files, 2020.

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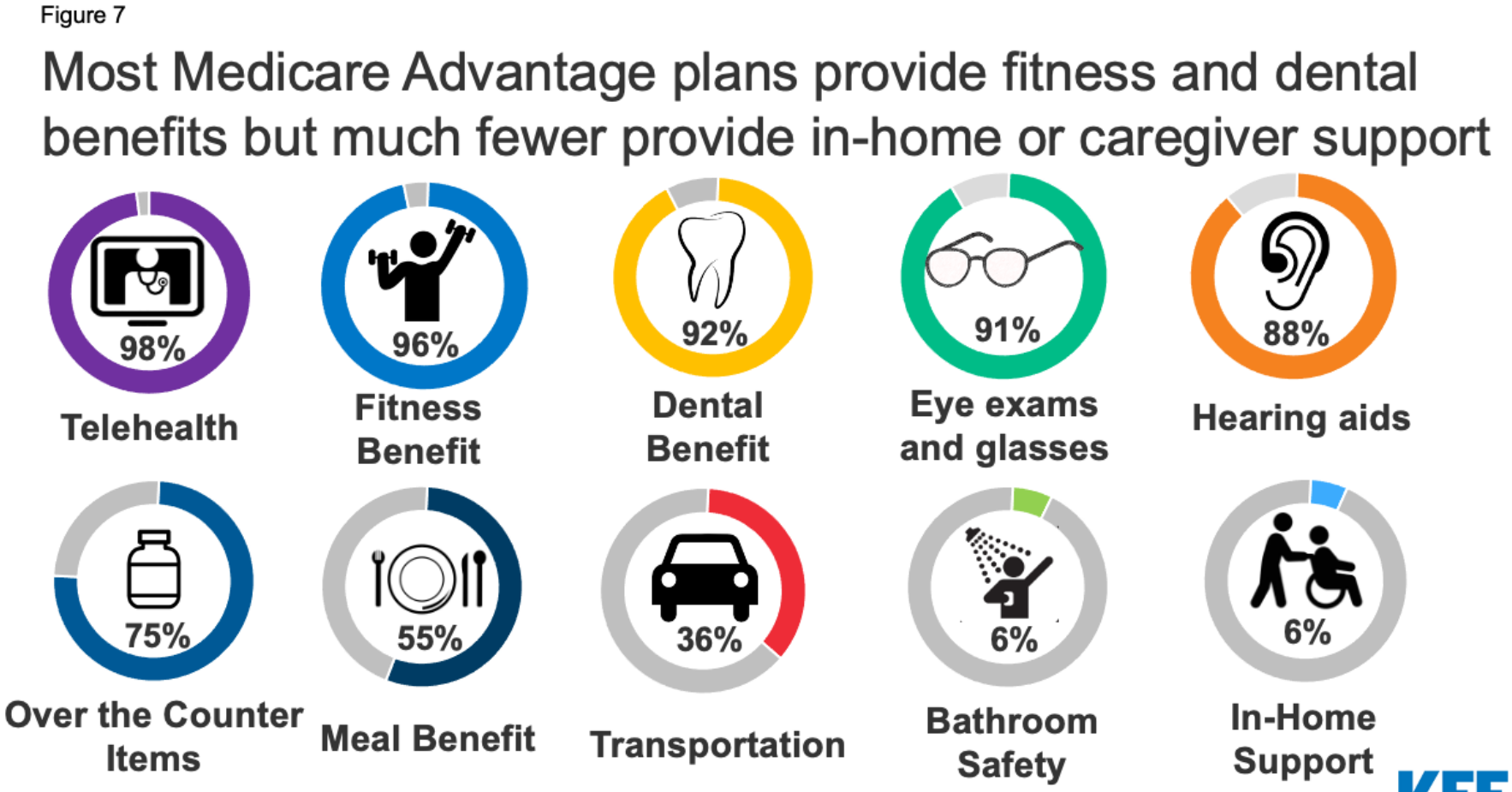
Extra Benefits in 2021

Figure 7



NOTE: Dental includes plans that only provide preventive benefits, such as cleanings. Excludes SNPs, EGHPs, HCPPs, and PACE plans.
SOURCE: KFF analysis of CMS's Landscape and Benefit files for 2021.

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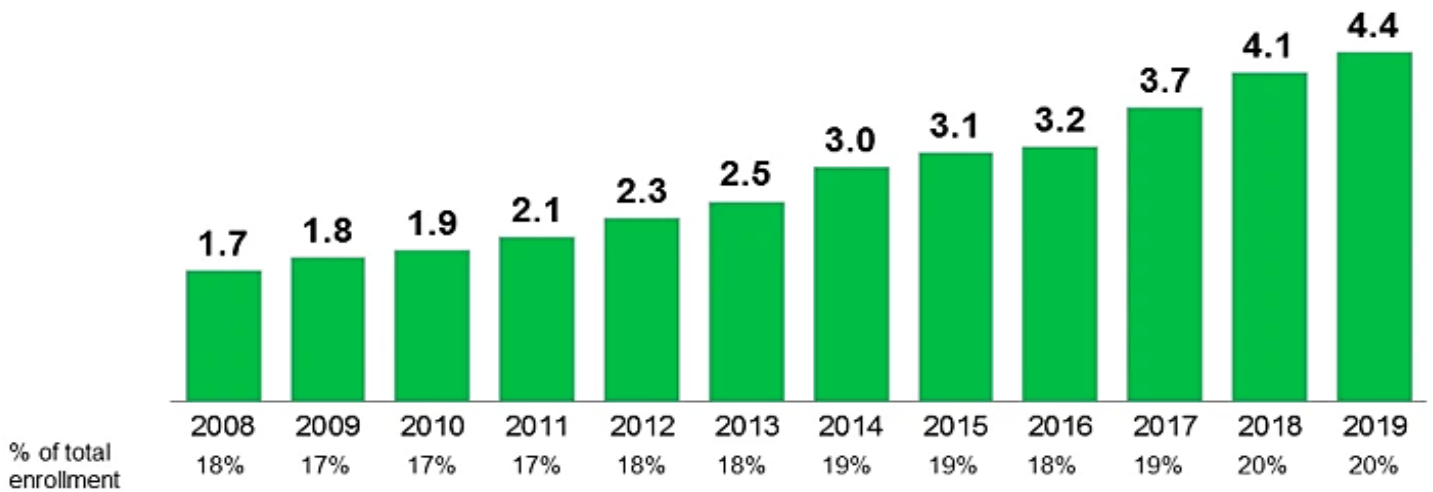
Group Enrollment

Figure 5

One in five Medicare Advantage enrollees are in employer or union-sponsored group plans in 2019

Total Medicare Advantage Enrollment in Employer/Union Sponsored Group Health Plans 2008-2019 (in millions)



SOURCE: Kaiser Family Foundation analysis of CMS Medicare Advantage enrollment files, 2008-2019.

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Segal

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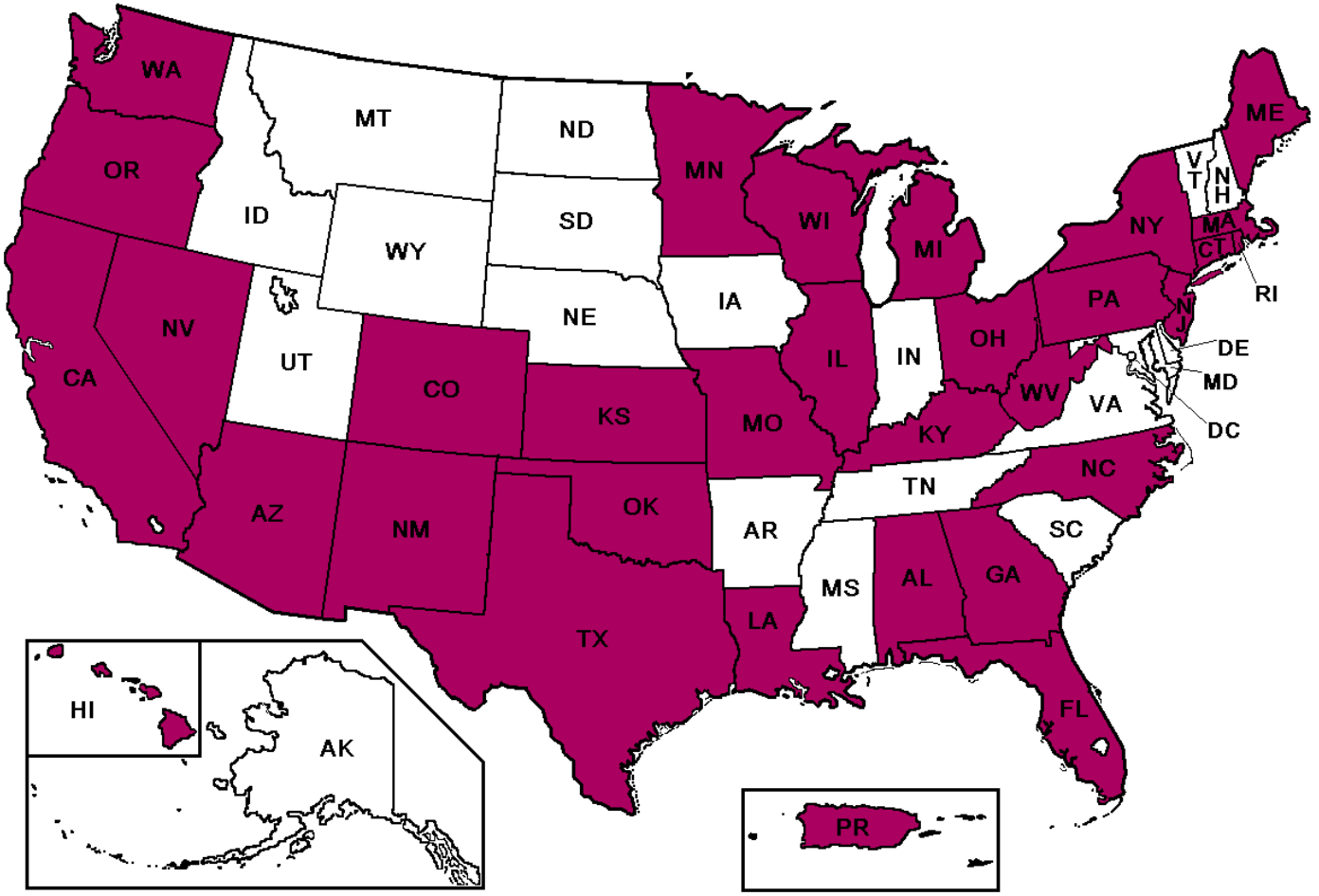
State Health Plans/Retirement Systems Offering Medicare Advantage



State system offers Medicare Advantage as an option, an opt-out, or total replacement (30 states + Puerto Rico).

Updated: 1/28/2020

Group Medicare Advantage PPO Differentiators

- Quantifiable savings and no financial risk with all-inclusive fully insured rate
- Maintain current benefit levels
- Nationwide provider access
- Simplified administration - all medical benefits covered under one plan
- All Medicare retirees can enroll regardless of where in the U.S. they live and obtain care
- Maintains single national plan design and rate consistency
- Ability to manage long-term risk with improved clinical and wellness programs
- Auto enrollment in group plan

Group Premium Pricing Components

Program Cost	
Claims Cost	$900.00
+ Admin	$50.00
= Total Cost	$950.00
CMS Revenue	
Benchmark	$950.00
X Risk Score	0.90
= CMS Funding	$855.00
Employer Premium	
Total Cost	$950.00
- CMS Funding	$855.00
= Group Premium	**$95.00**

3 Levers determine Group Premium sustainability:
Claims Cost, Benchmarks and Risk Scores

Clinical Programs Reduce Claims Cost

- Annual Wellness Visits
- Home Visit Programs
  - Referrals to Clinical Programs
- Care and Disease Management
  - Diabetes
  - Heart Failure
  - ESRD
  - Transplant
- Health and Wellness
  - Nurseline
  - Silver Sneakers Fitness
  - Caregiver Issues

Reduced Claims Cost Leverage on Group Premium Pricing

	Claims Costs Unmanaged	Claims Costs Reduced 2%	Claims Costs Reduced 4%	Claims Costs Reduced 6%	Claims Costs Reduced 8%
Program Cost					
Claims Cost	$900.00	$882.00	$864.00	$846.00	$828.00
+ Admin	$50.00	$50.00	$50.00	$50.00	$50.00
= Total Cost	$950.00	$932.00	$914.00	$896.00	$878.00
CMS Revenue					
Benchmark	$950.00	$950.00	$950.00	$950.00	$950.00
X Risk Score	0.90	0.90	0.90	0.90	0.90
= CMS Funding	$855.00	$855.00	$855.00	$855.00	$855.00
Employer Premium					
Total Cost	$950.00	$932.00	$914.00	$896.00	$878.00
- CMS Funding	$855.00	$855.00	$855.00	$855.00	$855.00
= Group Premium	**$95.00**	**$77.00**	**$59.00**	**$41.00**	**$23.00**

Change in Employer Premium	**-$18.00**	**-$36.00**	**-$54.00**	**-$72.00**
Change in Employer Premium	**-19%**	**-23%**	**-31%**	**-44%**

Appropriate Diagnosis Coding Increases Risk Scores

- Plans Encourage Members to go to the Doctor
  - Benefit Design
  - Gift Card Incentives
  - Clinically Integrated Advocate Programs
  - Home Visit Programs
- Plans Incent Doctors to Record Patient's Diagnosis Codes
  - Provider Relations
  - Training on Coding
  - Online Tools and Resources - UTUBE
  - Contract Incentives
- Plans Audit Diagnosis Codes
  - Software to Determine Patterns
- Coding is Critical
  - CMS Offsets Assumed Increases in Funding Each Year

Increased Risk Scores Leverage on Group Premium Pricing

	Risk Score Unmanaged	Risk Score Increased 2%	Risk Score Increased 4%	Risk Score Increased 6%	Risk Score Increased 8%
Program Cost					
Claims Cost	$900.00	$900.00	$900.00	$900.00	$900.00
+ Admin	$50.00	$50.00	$50.00	$50.00	$50.00
= Total Cost	$950.00	$950.00	$950.00	$950.00	$950.00
CMS Revenue					
Benchmark	$950.00	$950.00	$950.00	$950.00	$950.00
X Risk Score	0.90	0.92	0.94	0.95	0.97
= CMS Funding	$855.00	$872.10	$889.20	$906.30	$923.40
Employer Premium					
Total Cost	$950.00	$950.00	$950.00	$950.00	$950.00
- CMS Funding	$855.00	$872.10	$889.20	$906.30	$923.40
= Group Premium	**$95.00**	**$77.90**	**$60.80**	**$43.70**	**$26.60**

Change in Employer Premium	**-$17.10**	**-$34.20**	**-$51.30**	**-$68.40**
Change in Employer Premium	**-18%**	**-36%**	**-54%**	**-72%**

High Star Ratings Increase Benchmarks

- Star Ratings are Scores of Quality Measures
  - Based on Quality of Care
  - By CMS Contract
  - Cutpoints for Measures are Unknown by Carriers
- Higher Star Ratings Receive Higher Benchmark Payments
  - Plans with 4.0 and higher Star Rating receives 5% Higher Benchmarks than < 4.0 Star Rating
- Measures are Based On:
  - Staying healthy: screenings, tests, vaccines
  - Managing chronic (long-term) conditions
  - Member experience with the health plan/drug plan
  - Member complaints, problems getting services, and improvement in the health/drug plan's performance
  - Health/drug plan customer service
  - Patient safety and accuracy of drug pricing

Savings Potential for ASE

Moving to Medicare Advantage (MA)

Cash Savings Estimate

	Low Estimate	High Estimate
Estimated Medical Claims[1]	$31,000,000	
MA Savings Opportunity	20%	60%
Potential Cash Savings	**$6,000,000**	**$19,000,000**

- We estimate an opportunity to save between $6 and $19M in claims costs compared to current medical claims
  - Savings range based on our experience with other clients that have transitioned to MA

[1] Based on 2020 paid claims provided by Health Advantage for Medicare retirees

Savings Potential for ASE

Moving to Medicare Advantage (MA)

Liability Savings Estimate

	Low Estimate	High Estimate
OPEB Liability[2]	$2,600,000,000	
MA Savings Opportunity	20%	60%
Post-65 Liability Estimate	45%	60%
Medical Portion of Post-65 Liability	45%	50%
Potential Liability Savings	**$105,000,000**	**$468,000,000**

- Liability savings are more significant, ranging from $105M to $468M
  - Liability ranges are estimates based on experience with other Public Sector retiree programs

[1] June 30, 2020 liability for Arkansas State Employees, as prepared by Milliman

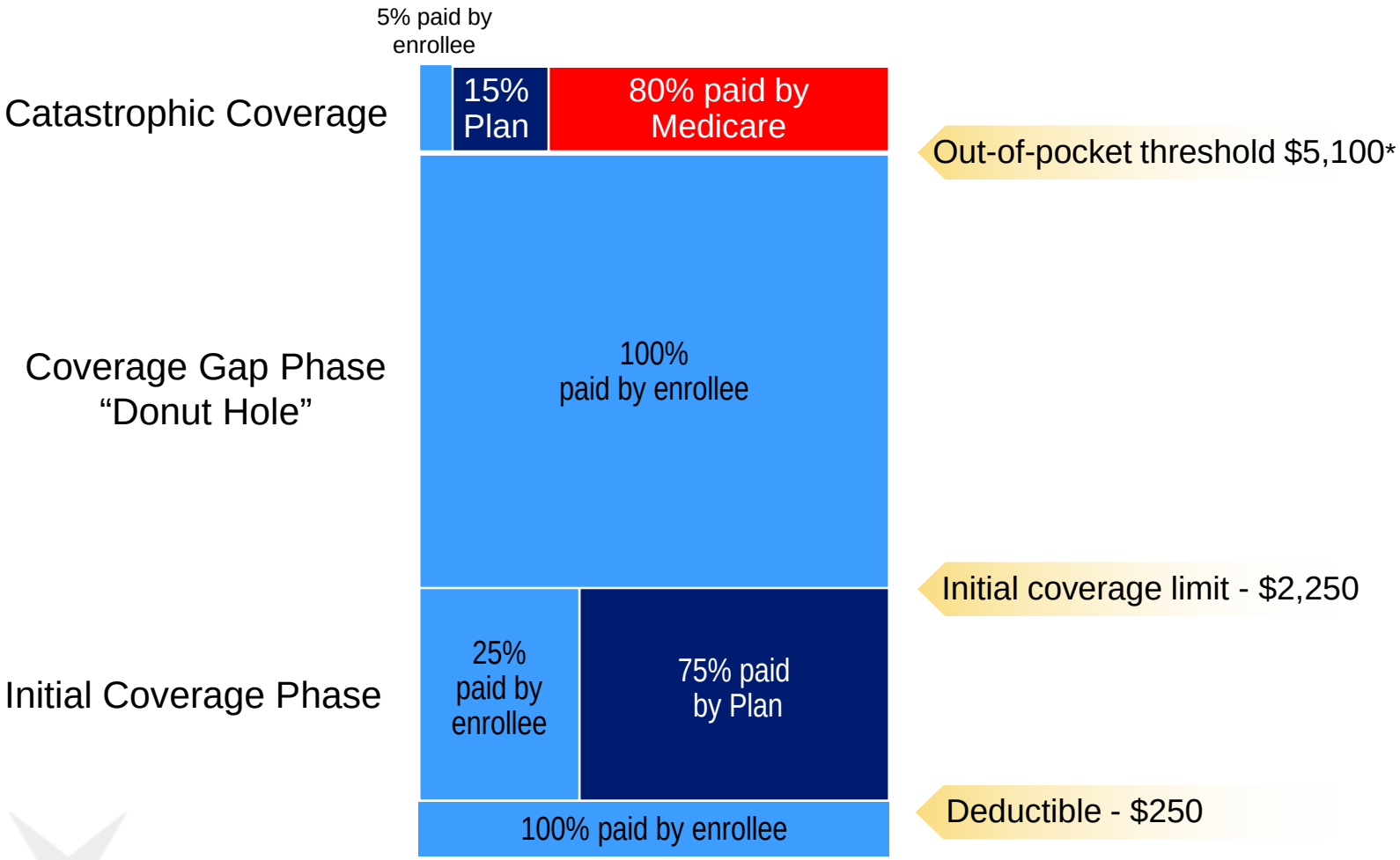
Part D

Medicare Part D Key Dates

- 2006 – Medicare Part D drug coverage introduced (Medicare Modernization Act)
  - Commercial and Group Part D (EGWP) plans introduced
  - Retiree Drug Subsidy established
- 2011 – Part D Enhancements (Patient Protection and Affordable Care Act)
  - Coverage Gap Discount (50% discount for brand-name drugs)
  - Phase-out of coverage gap by 2020
  - EGWP + “Wrap” benefit developed
- 2013 – New CMS Rules (Centers for Medicare and Medicaid Services)
  - Claim processing rule changes eliminates need for “Wrap”
- 2019 – Part D Enhancements (Bipartisan Budget Act of 2018)
  - Coverage Gap Discount increases to 70%
- 2020 – Coverage Gap phase-out complete

Original Standard Part D Benefit

STANDARD MEDICARE PRESCRIPTION DRUG BENEFIT, 2006



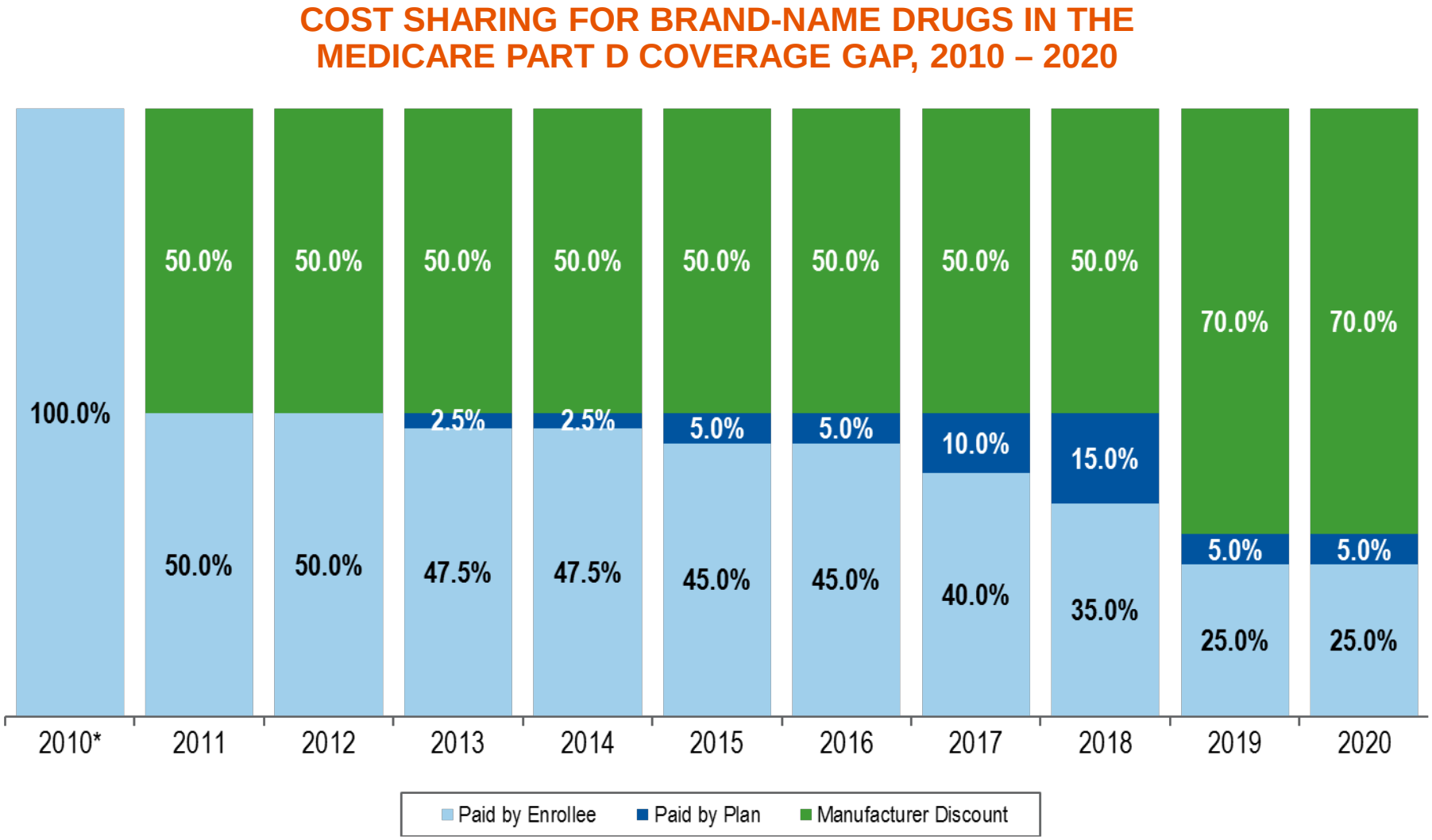
* Corresponds to an out of pocket threshold for catastrophic coverage of $3,600

Original RDS Subsidy Process

- **Retiree Drug Subsidy**:
  - 28% of each eligible retiree's drug spend between $250 and $5,000
  - Excludes non-Medicare Part D drugs
  - Must be net of all formulary rebate payments
  - Plan must file an actuarial equivalence accreditation annually
  - Plan must send each participant credible coverage notice annually

RDS was designed to encourage employers to continue offering prescription drug benefits to their retirees with subsidies designed to produce similar reimbursement to Part D

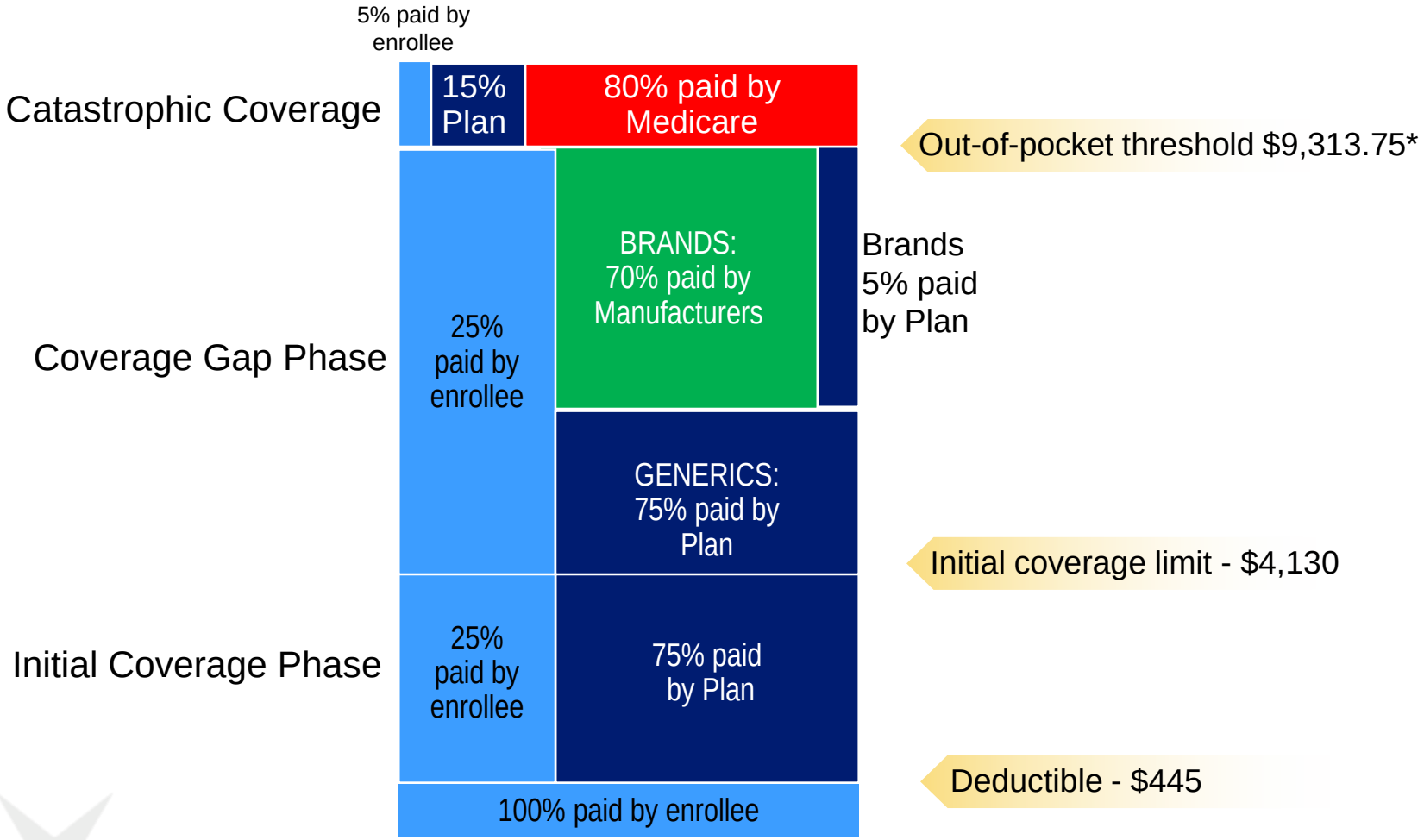
Medicare Part D
Phase out of coverage gap – brand drugs



* In 2010, participants reaching the coverage gap received $250 rebate.

Standard Part D Benefit

STANDARD MEDICARE PRESCRIPTION DRUG BENEFIT, 2021



* Corresponds to an out of pocket threshold for catastrophic coverage of $6,550

What is an Employer Group Waiver Plan (EGWP)?

A group sponsored Medicare Part D prescription drug plan with an enhanced benefit beyond the Standard Part D benefit

- EGWP's are true Medicare Part D plans, largely regulated by CMS. However, CMS is required to grant waivers to encourage use of plans by employers. For example, employers can have custom enrollment periods and custom communications.
- An EGWP plan design is customizable to mirror current plan design as long as the plan is as good or better than the standard Part D benefit level.
- The Medicare Part D Coverage Gap Discount Program is available to EGWPs.
- An EGWP also provides for catastrophic reinsurance (for costs beyond coverage gap)
- Low-income subsidies are available for eligible participants

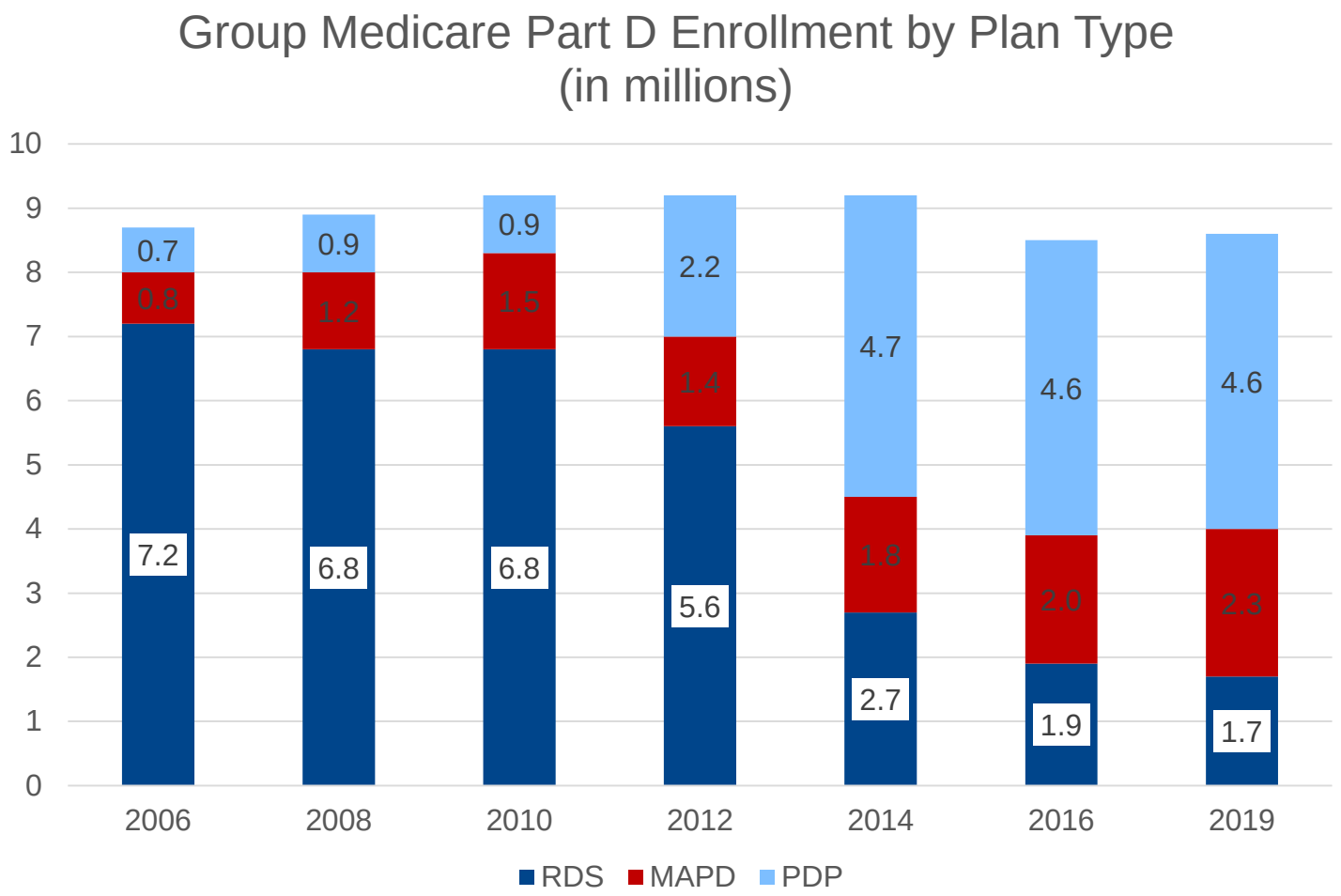
EGWP Standard Plan Design—
Plus Enhancement to Match Existing Plan

Part D benefit stage†	Rx drug costs	Standard Part D plan	EGWP plan design available enhancements
1 Deductible	$0 – $445	Retiree pays 100% of the network discounted cost.	• Eliminate the deductible
2 Initial coverage	$445 – $4,130	The retiree is considered "in-benefit" and pays the applicable 25% coinsurance.	• Modify copay/coinsurance to equal current plan design
3 Coverage gap	$4,130 – **$6,550 TrOOP***	Coverage Gap Discount Program (70% discount on brands). The retiree pays 25% coinsurance.	• Modify copay/coinsurance to equal current plan design
4 Catastrophic coverage	**$6,550+ TrOOP**	The retiree pays 5% coinsurance.	• Plan can cap coinsurance but cannot exceed CMS mandated coinsurance

† For EGWP, only two phases are required by CMS (Initial Coverage and Catastrophic Coverage). Dollar amounts are for 2020.

* True Out-of-Pocket includes member cost share and coverage gap discount.

Medicare Part D Enrollment Compared to RDS

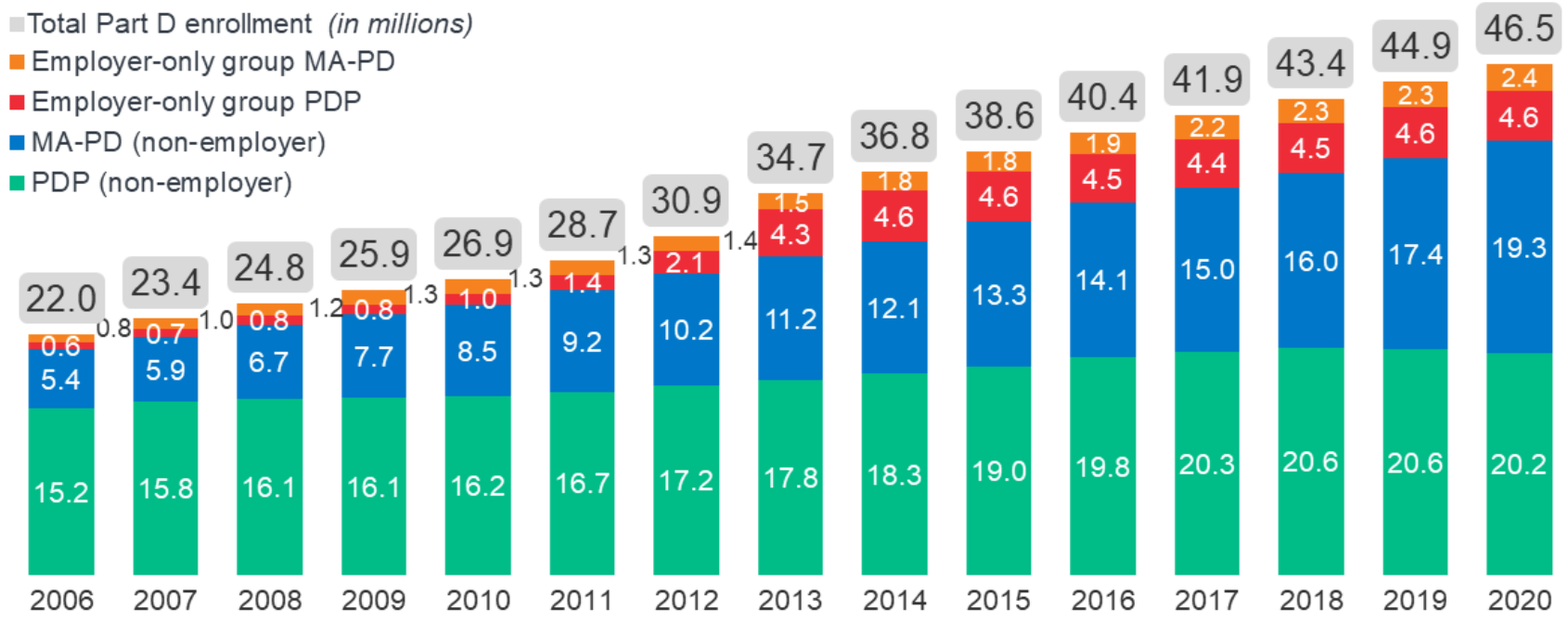


Source: Kaiser Family Foundation Issue Brief June 4, 2019

Total Part D Enrollment by Type of Coverage

Figure 4

Medicare Part D Enrollment in Stand-Alone Drug Plans Has Declined Recently But Has Increased Steadily in Medicare Advantage Drug Plans



NOTE: Includes enrollment in the territories and in employer-only group plans. PDP is stand-alone prescription drug plan. MA-PD is Medicare Advantage prescription drug plan.

SOURCE: KFF analysis of Centers for Medicare & Medicaid Services 2006-2020 Part D plan files.

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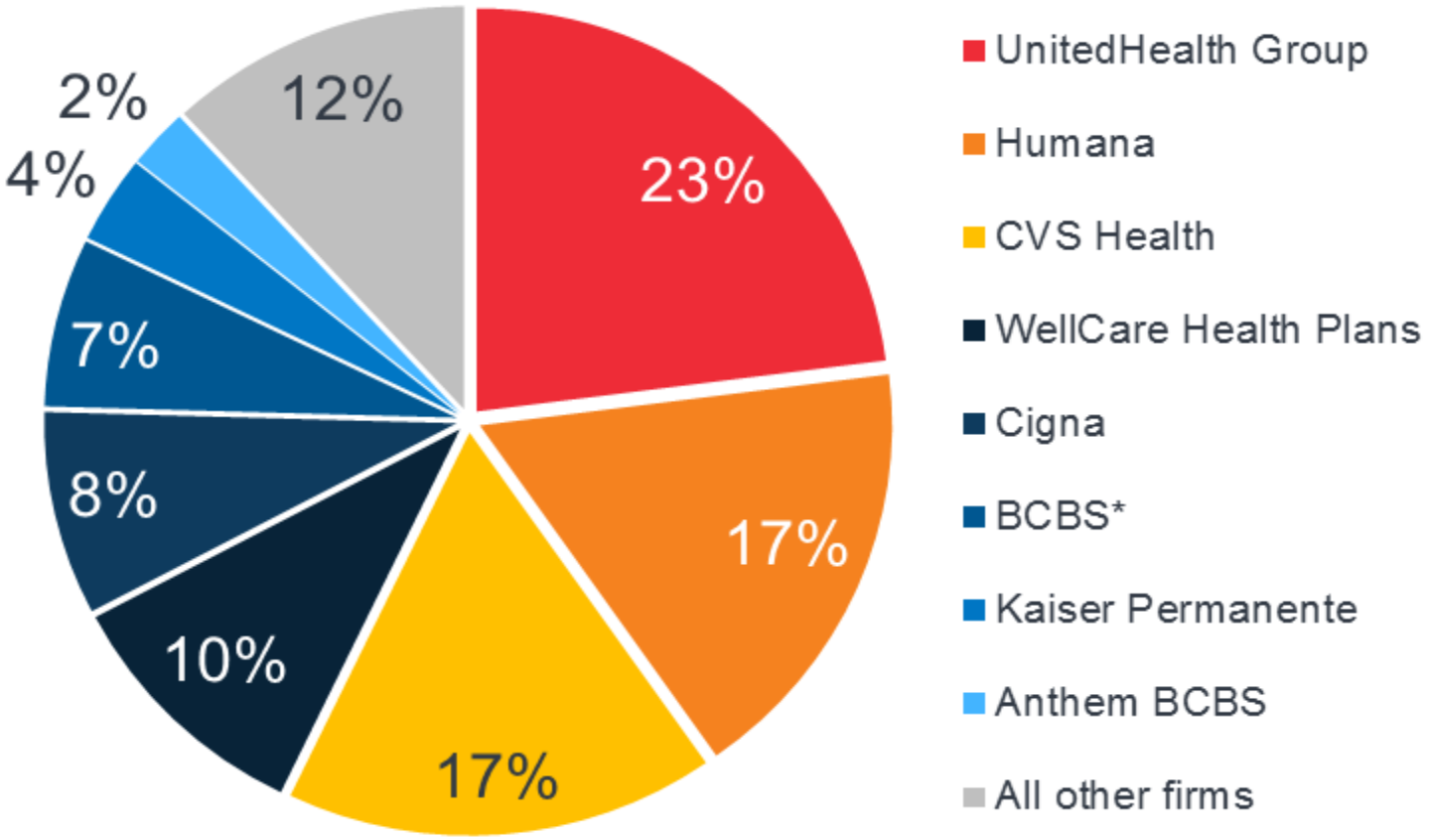
Figure 3

Distribution of Medicare Part D Enrollment by Firm in 2019



Total Part D Enrollment in 2019 = 44.9 million

NOTE: Includes enrollment in the territories and employer-only group plans. *BCBS excludes Anthem BCBS, which is a separate plan sponsor.
SOURCE: KFF analysis of Centers for Medicare & Medicaid Services 2019 Part D plan files.

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Savings Provided by Additional EGWP Subsidies

	RDS	EGWP
Description	Employer-sponsored programs that are actuarially equivalent or better than the standard Part-D drug benefit are eligible for the RDS subsidy.	PDP contracts directly with CMS. Plan design is actuarially equivalent or better than the Standard Part-D plan design.
RDS Subsidy	Maximum RDS Subsidy is capped at 28%* (Cost Treshold - Cost Limit)	Not Applicable to EGWP plans
Coverage Gap Discount Program Subsidy	Not Applicable to the RDS program	Plan sponsor receives a 70% discount on brand drugs in the coverage gap hole. This counts toward the retirees' TROOP and pushes through the coverage gap faster.
Catastrophic Reinsurance Subsidy	Not Applicable to the RDS program	80% of Cost over the catastrophic threshold less applicable rebates.
Part-D Direct Subsidy	Not Applicable to the RDS program	Risk Adjusted Payment made by CMS directly to PDP for each Part-D participant.
Low Income Subsidy (LIS)	Not Applicable to the RDS program	LIS participants experience no coverage gap and no cost sharing above Part-D OOP threshold. The LIS mitigates the cost of the plan sponsor of covering these beneficiaries.

Savings Potential for ASE

Moving to Employer Group Waiver Plan (EGWP)

Cash Savings Estimate

	Low Estimate	High Estimate
Estimated Rx Claims (net of rebates and RDS)[1]	$25,500,000	
EGWP Savings Opportunity	20%	40%
Potential Cash Savings	**$5,000,000**	**$10,000,000**

- We estimate an opportunity to save between $5 and $10M in claims costs compared to current Rx claims
  - Savings range based on our experience with other clients that have transitioned to EGWP, as well as review of estimate prepared by MedImpact

[1] Based on EGWP Savings Estimate provided by MedImpact

Savings Potential for ASE

Moving to Employer Group Waiver Plan (EGWP)

Liability Savings Estimate

	Low Estimate	High Estimate
OPEB Liability[1]	$2,600,000,000	
EGWP Savings Opportunity	35%	50%
Post-65 Liability Estimate	45%	60%
Rx Portion of Post-65 Liability	50%	55%
Potential Liability Savings	**$205,000,000**	**$429,000,000**

- Liability savings are more significant, ranging from $205M to $429M
  - Savings estimate is higher than on a cash basis, since RDS subsidies cannot be included in GASB cash flows
  - Liability ranges are estimates based on experience with other Public Sector retiree programs

[1] June 30, 2020 liability for Arkansas State Employees, as prepared by Milliman

Prescription Drug Legislative Proposals

- Most Favored Nations Model
  - Targets Medicare Part B drug spending by tying Medicare reimbursement to the lowers price paid by certain countries.
- Removing Safe Harbor for Medicare Drug Rebates
  - Transition rebates to Point of Sale
- Prescription Drug Importation
  - From Canada or other countries
- Part D Redesign
  - Several proposals in recent years
- Drug Price Inflation Rebates
- Medicare Drug Price Negotiation

Challenges for Public School Medicare Retirees

- Currently have no plan sponsored benefits for pharmacy
- Members cannot be enrolled in an EGWP plan and an individual plan simultaneously
- CMS will automatically remove a member from existing coverage when enrolled in another plan
- The only option for PSE to consider a Medicare Advantage plan is if PSE would want to explore the potential to cover Medicare Advantage with Part D. It may be possible to reduce PSE cost of medical coverage enough with a MAPD to cover the cost of pharmacy benefits, but this would need to be further reviewed and likely vetted in the market.

Questions?