## Educational Sessions Schedule
### Medicare RFP and Prescription Drug Review

<table>
<thead>
<tr>
<th>PEC Meeting Date</th>
<th>Discussion Topic</th>
</tr>
</thead>
<tbody>
<tr>
<td>February 9</td>
<td>Medicare 101</td>
</tr>
<tr>
<td>March 8</td>
<td><strong>Medicare Part C (Medicare Advantage)</strong></td>
</tr>
<tr>
<td>April 12</td>
<td>Prescription Drug Carve-out</td>
</tr>
<tr>
<td>May 10</td>
<td>Medicare Part D (Prescription Drugs)</td>
</tr>
<tr>
<td>June 14</td>
<td>Review and Planning for RFPs</td>
</tr>
</tbody>
</table>
## Retiree Medical Plan Options
### Current City Plans

<table>
<thead>
<tr>
<th>Plan Type</th>
<th>Plan Name</th>
<th>Network</th>
<th>Funding Arrangement</th>
<th>Drug Coverage(^1)</th>
<th>January 2016 Enrollment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare Supplement (Medigap)</td>
<td>HPHC Medicare Enhance</td>
<td>No</td>
<td>Self-Funded</td>
<td>RDS</td>
<td>4,563</td>
</tr>
<tr>
<td></td>
<td>Tufts Preferred Supplement</td>
<td>No</td>
<td>Fully Insured</td>
<td>PDP</td>
<td>1,693</td>
</tr>
<tr>
<td>Medicare Supplement</td>
<td>BCBS Managed Blue for Seniors(^2)</td>
<td>Yes</td>
<td>Fully Insured</td>
<td>RDS</td>
<td>424</td>
</tr>
<tr>
<td>Medicare Advantage</td>
<td>Tufts Medicare Preferred HMO</td>
<td>Yes</td>
<td>Fully Insured</td>
<td>MA-PD</td>
<td>218</td>
</tr>
<tr>
<td></td>
<td>BCBS Medicare HMO Blue</td>
<td>Yes</td>
<td>Fully Insured</td>
<td>MA-PD</td>
<td>49</td>
</tr>
<tr>
<td>Medicare Carve-out</td>
<td>BCBS Master Medical Carve-out(^3)</td>
<td>No</td>
<td>Self-Funded</td>
<td>RDS</td>
<td>3,769</td>
</tr>
</tbody>
</table>

\(^1\) RDS = Retiree Drug Subsidy, PDP = Medicare Prescription Drug Plan, MA-PD = Medicare Advantage with Prescription Drugs

\(^2\) BCBS Managed Blue for Seniors is a network-based product, but is not filed as a Medicare Advantage plan

\(^3\) BCBS Master Medical Carve-out plan will be discontinued effective July 1, 2017, per PEC Agreement
# Group Retiree Medical Plan Options

**Medicare Supplement (Medigap) vs Medicare Advantage (Part C)**

<table>
<thead>
<tr>
<th>Plan Type</th>
<th>Medicare Supplement (Medigap)</th>
<th>Medicare Advantage (Medicare Part C)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>City’s Current Plans</strong></td>
<td>● HPHC Medicare Enhance</td>
<td>● Tufts Medicare Preferred HMO</td>
</tr>
<tr>
<td></td>
<td>● Tufts Preferred Supplement</td>
<td>● BCBS Medicare HMO Blue</td>
</tr>
<tr>
<td><strong>Plan Design</strong></td>
<td>● Coverage is intended to “fill in the holes” (i.e., supplement) coverage provided by Medicare Parts A and B</td>
<td>● Coverage is intended to “replace” Medicare Parts A and B</td>
</tr>
<tr>
<td></td>
<td>● No network requirements—can see any provider that accepts Medicare</td>
<td>● Includes all benefits and services covered under Part A and Part B</td>
</tr>
<tr>
<td></td>
<td>● Provided by private insurance carriers</td>
<td>● Many plans require an enrollee to see a provider in the carrier’s network</td>
</tr>
<tr>
<td></td>
<td></td>
<td>● Provided by private insurance carriers</td>
</tr>
<tr>
<td><strong>Funding</strong></td>
<td>● Can be fully-insured or self-funded</td>
<td>● Must be fully insured</td>
</tr>
<tr>
<td></td>
<td>● Carriers coordinate with Medicare on a fee-for-service basis</td>
<td>● Could be experience-rated for large group</td>
</tr>
<tr>
<td></td>
<td></td>
<td>● Carriers receive a specified subsidy from CMS for each enrollee</td>
</tr>
<tr>
<td><strong>Prescription Drug Coverage</strong></td>
<td>● Most Medigap plans do not provide drug coverage, although an employer could provide a group plan with Rx and apply for RDS (Retiree Drug Subsidy)</td>
<td>● May be combined with a Medicare Advantage Prescription Drug, known as an MA-PD</td>
</tr>
<tr>
<td></td>
<td>● Otherwise, must be provided through a separate PDP (Medicare Prescription Drug Plan). This can appear integrated from the retiree’s perspective</td>
<td>● May also be provided through a separate PDP</td>
</tr>
</tbody>
</table>
Medicare Advantage

Financial

- **Medicare Advantage Plans** receive fixed dollar subsidies per enrollee (capitations) from CMS based on an annual bid process
  - Plan costs are offset by CMS subsidy; difference represents the Medicare Advantage Plan premium
  - Carriers manage all claims, risk adjustment and clinical programs
  - Carriers assume all the risk which gives them the incentive to control costs

- **Risk Adjustment**
  - In addition to base monthly fee, a risk-adjustment process adjusts payments made to plans based on health history and status of enrollees
  - Increased subsidies for enrollees who will cost more
  - Decreased payments for healthier enrollees
  - Similar risk-adjustment processes exist for Medicare Part D (prescription drug plans) and plans sold on ACA Exchanges (Marketplaces)

- **Bonus Payments**
  - Plans are rated on a 5-star scale that evaluates outcomes and patient experiences
  - Plans with ratings of 4 to 5 are eligible for bonus subsidy payments from CMS

- **Affordable Care Act (ACA) and Medicare Advantage**
  - ACA reduced payments to Private Sector Medicare Advantage plans
    - Some of these reductions were subsequently reversed
  - Medicare Advantage plans are now required to disclose loss ratios. For plans with loss ratios less than 85%, the Affordable Care Act requires rebates to participants
Medicare Advantage
Plan Types

Medicare Health Maintenance Organizations (HMO)
- Filed on county by county basis
- Rates vary from county to county; for groups, one average composite rate provided
- Provides coverage through a network of locally contracted doctors and hospitals
- Generally do not provide coverage outside the network of contracted providers, except in emergencies

Medicare Preferred Provider Organization (PPO)

Regional PPO
- Plan members choose between in-network and out-of-network providers
- Participant’s costs may increase if seeing a non-network provider
- Plans cover all medically-necessary covered benefits, whether they’re received in network or not
- Member can usually see a specialist without a referral
- Locally, only BCBS of Massachusetts offers a PPO option

National Passive PPO
- If a regional PPO provides coverage to at least 51% of the members in a “service area”, it can provide coverage on a national passive PPO basis (provides same level of benefits to those outside the service area, assuming those providers accept Medicare)
- Offers same member cost sharing and benefits whether using in-network or out-of-network providers
- In a Passive PPO, member may not be aware of the underlying network
- Major carriers offering this product: UnitedHealthcare, Aetna/Humana*
  * Aetna and Humana are expected to merge. Currently, neither carrier offers a Medicare Advantage product in Boston (02201) per Medicare.gov.
Medicare Advantage
Enrollment by State (2015 data)

NATIONAL AVERAGE 2015 = 32%

- <10% (6 states)
- 10% – 19% (10 states + DC)
- 20% – 29% (11 states)
- ≥30% (22 states)
Based on data published by CMS, as of July 2015, 21% of Massachusetts residents who are eligible for Medicare Advantage coverage are enrolled in a Medicare Advantage plan:

- Enrollment varies between 1% (Nantucket and Dukes County) and 35% (Worcester County)
- Suffolk County enrollment was 22%

Among City of Boston Medicare retirees, current enrollment is only 2.5%

Nationwide, Medicare Advantage enrollment was 32%

Medicare.gov shows the following carriers with Medicare Advantage plans available in Boston (02201):

- Blue Cross Blue Shield of Mass.
  - HMO and PPO
- Fallon Health
  - HMO
- Harvard Pilgrim Health Care
  - HMO
- Tufts Health Plan
  - HMO
- UnitedHealthcare (AARP)
  - HMO
Medicare Advantage
Massachusetts – Enrollment by County (2015 data)
Medicare Advantage

Summary

Costs and premiums
- Federal CMS funding covers a large portion of plan costs typically resulting in significant savings
- Can provide comparable level of current plan benefits in a more cost effective manner (due to capitated payments)
- Premium rates (i.e., cost) depend on plan design and the level of CMS funding
- Enrollee still must pay Medicare Part B premium!

Insurer perspective
- Capitated payments give carriers more incentive to manage costs compared to Medicare Supplement plans (where most of the benefit of costs savings accrues to Medicare)
- Insurers also lower costs by implementing programs that support and manage the health of the population
  - Disease and case management to help members effectively navigate the health care system
  - Wellness and chronic condition management provided to ensure savings over long term