NATIONAL INSTITUTE FOR
PUBLIC EMPLOYEE
HEALTH CARE POLICY

The Value of Medicare Advantage Employer Group Waiver Plans in the Public Sector: An Introduction

National Institute for Public Employee Health Care Policy

May 9, 2024

About the National Institute for Public Employee Health Care Policy

Over 13 percent of the American workforce is employed by public sector employers, and health care benefits are a crucial component of their compensation programs. Public sector purchasers serve tens of millions of employees and retirees who have spent decades serving in critical roles such as teachers, firefighters, and law enforcement across the country and have a fiduciary duty to offer high-quality, comprehensive benefits at an affordable cost.

The National Institute for Public Employee Health Care Policy (the Institute) is a non-profit (501) (c)(3), nonpartisan, national policy institute focused on public policy areas impacting health care plans available to public sector employees, retirees, and their beneficiaries. The Institute conducts research, develops authored papers and issue briefs, and hosts events to raise awareness and educate the Washington, D.C. policy community. Visit our website at healthcarepolicy-institute.org.

Table of Contents

Executive Summary

Plan sponsors in the public sector, such as those who provide health coverage to teachers, firefighters, and law enforcement, are increasingly turning to Medicare Advantage Employer Group Waiver Plans (MA-EGWPs) to provide Medicare benefits to their employees, retirees, and dependents. In 2023, enrollment in MA outpaced Original Medicare, and half of plan sponsors providing retiree benefits offer MA-EGWPs. MA-EGWPs help to address the following for retirees and plan sponsors:

- Benefits plus quality oversight: MA-EGWPs provides robust coverage and supplemental benefits for seniors with built-in cost-sharing protections.
- Greater payment stability: Stable, risk-adjusted payments protect plan sponsors' bottom line and allow plans to provide new benefits to members.
- Benefits flexibility of MA-EGWP: Employer Group Waiver Plans can adapt to meet retiree needs and respond to emerging trends.
- Health equity and social risk factors: MA plans advance equity and reduce health disparities within Medicare.
- Impact of the Inflation Reduction Act (IRA): Evolving legislation for all Part D plans, including benefit design and Medicare drug negotiation, will further protect enrollees from out-of-pocket costs.

Given the sizable role MA-EGWPs play in retiree benefits for Public Sector purchasers, and the limited information available within this critical segment of the American workforce, further research is needed so policy makers understand the role MA-EGWPs currently play and the benefits they provide.

Introduction

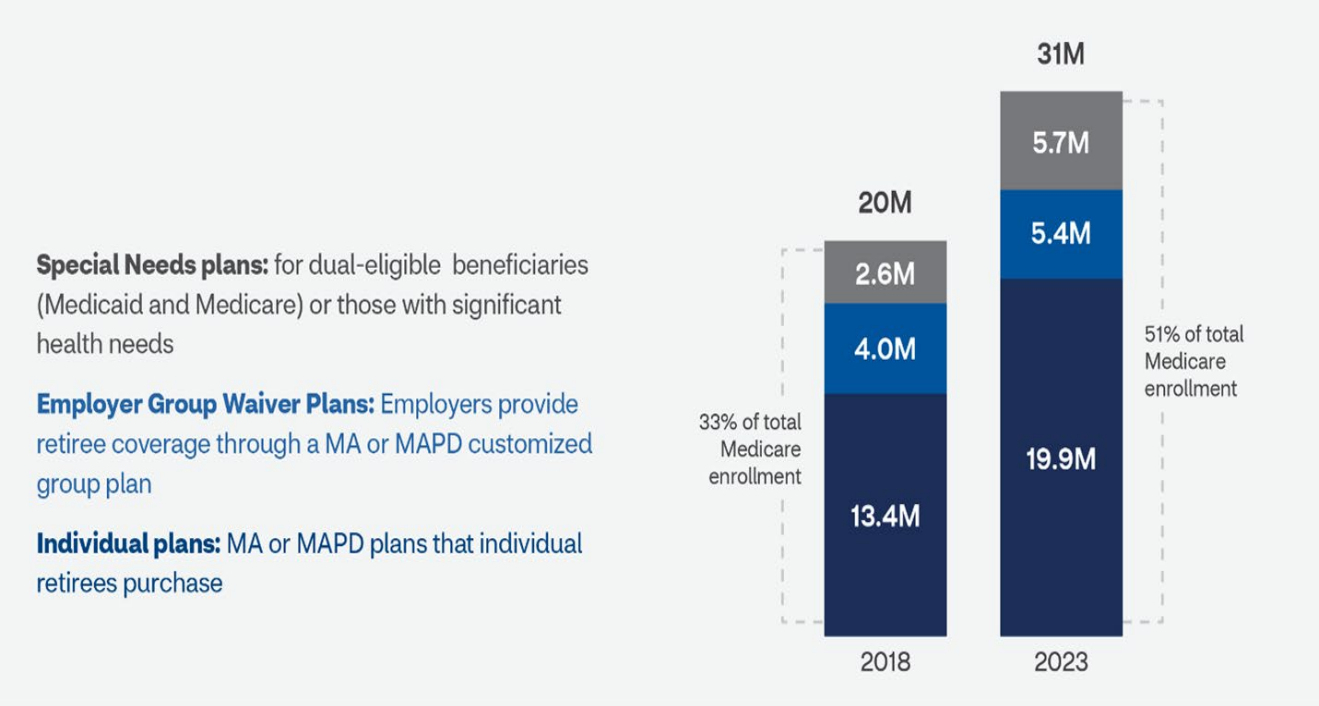
Since the introduction of Medicare Advantage (MA) more than 20 years ago, the number of people choosing MA plans has increased steadily. In 2023, 51 percent or 30.8M of all Medicare beneficiaries signed up for MA, up from 33 percent in 2018 (Figure 1).[1] By 2033, 62 percent are expected to join MA.[2]

Medicare Advantage, known as Part C, covers the same services as Original Medicare Parts A and B and often includes additional benefits[3,4]—on average, $600 worth of supplemental benefits to each participant.[5]

Medicare Advantage also offers:

- Out-of-pocket (OOP) protections that limit annual medical expenses
- Integrated plans that include Part D prescription drug coverage
- A high member satisfaction rate of 94 percent.[6]

Figure 1: MA enrollment by plan type in 2018 and 2023[7]



MA-EGWPs provide predictable public sector retiree medical coverage

As health care costs continue to rise, public sector purchasers, unions and trusts are using Medicare Advantage Employer Group Waiver Plans (MA-EGWP) to maintain or enhance coverage for beneficiaries, while reducing both immediate costs and long-term liabilities.

Plan sponsors in the public sector, such as those who provide health coverage to teachers, firefighters, and law enforcement, often purchase MA-EGWPs to provide Medicare benefits to their employees, retirees, and their dependents. Comprising around 13% of the American workforce, these public sector employees typically receive modest incomes combined with quality, low-cost-sharing health benefits. This combination is especially crucial for this demographic, given their complex care needs as they age. These frequently encounter occupational hazards such as exposure to harmful substances and high-stress environments. Consequently, they experience a higher prevalence of chronic conditions and disabilities during retirement, leading to complex healthcare needs among these beneficiaries.

Retiree health benefits, often through MA-EGWPs, are an integral piece to their overall compensation structure .[8] Notably, public sector purchasers constitute the majority of MA-EGWP enrollments.[9] In MA-EGWP arrangements, plan sponsors contract with private insurers for retiree health coverage, and the insurer contracts with the Centers for Medicare & Medicaid Services (CMS), the federal agency that regulates quality and payment oversight for all Medicare Advantage plans based on plan performance. Half of plan sponsors providing retiree benefits offer MA-EGWPs.

These public-private partnerships provide plan sponsors:

- Sustainable costs that can reduce a public or private entity's Other Post-Employment Benefits (OPEB) liabilities
- Robust coverage that matches or exceeds current retiree benefits and includes all Original Medicare services
- Coordinated patient care and streamlined administration

The affordable cost and financial stability of MA-EGWPs make them an increasingly attractive option for retiree benefits, especially those in the public sector.

Benefits and quality ratings

MA-EGWPs include all Part A and Part B services covered by Original Medicare, with additional benefits, care coordination and quality ratings. In addition, patient cost sharing aligns actuarially with Original Medicare (Table 1). Plans encourage coordinated, efficient, value-based care instead of fee-for-service arrangements. This means MA-EGWP plans frequently engage in contractual agreements with providers, reimbursing a capitated amount per member (plus quality incentives), rather than compensating for each individual service a member utilizes.

CMS offers incentives to all MA plans to provide high-quality care and continuous quality improvement through the Star Rating System. This program evaluates a plan's quality of health management and outcomes on a scale of 1-5 stars, with 5 being the highest quality. CMS rewards plans that earn higher Star Ratings with higher payments. Plans can use these payments to offer more services, lower OOP costs, or reduce premiums. An analysis from the Kaiser Family Foundation found MA-EGWPs have higher-than-average Star Ratings.[10]

Table 1: Key differences between employer-sponsored Medicare Advantage and Original Medicare

Topic	Medicare Advantage EGWP	Original Medicare
Part A (hospital) and Part B (medical) coverage	All A and B covered services (Part C)	All A and B covered services
Supplemental benefits	Majority include some additional benefits (e.g., dental, vision care, hearing benefits, transportation), wellness programs	Not covered
Out-of-pocket (OOP) costs	Annual OOP limit for Parts A and B; members cannot purchase Medigap plans; cost sharing (e.g., copays, deductibles) may be lower than Original Medicare	No OOP limit for Parts A and B, but beneficiaries can purchase Medigap plans to reduce OOP costs
Provider access	Network of providers that meets adequacy standards, and may include higher costs for out-of-network services	No networks; beneficiaries can see any provider who accepts Medicare
Part D, Prescription Drug Plan (PDP)	Medicare Advantage Prescription Drug (MAPD) plans integrate MA with Part D, or plan sponsors can offer as a separate standalone PDP	Beneficiaries can enroll in a standalone PDP for an additional premium
Quality measurement	MA plan quality (e.g., health outcomes, patient experience) is measured through the Star Rating program	Providers and facilities participate in quality measurement programs that may alter their payment

Growth of MA-EGWP

Both public and private sector employers regularly provide health care coverage to retirees and Medicare-eligible employees. Among large firms offering health benefits to active workers, 21 percent also offer retiree health benefits[11]. Moreover, 59 percent of employers now offer MA-EGWPs with prescription drug coverage (MAPD-EGWPs) (Figure 2).

In 2022, 50 percent of large employers offering health benefits to retirees and Medicare-eligible employees offered some of these benefits through a MA-EGWP.[12]

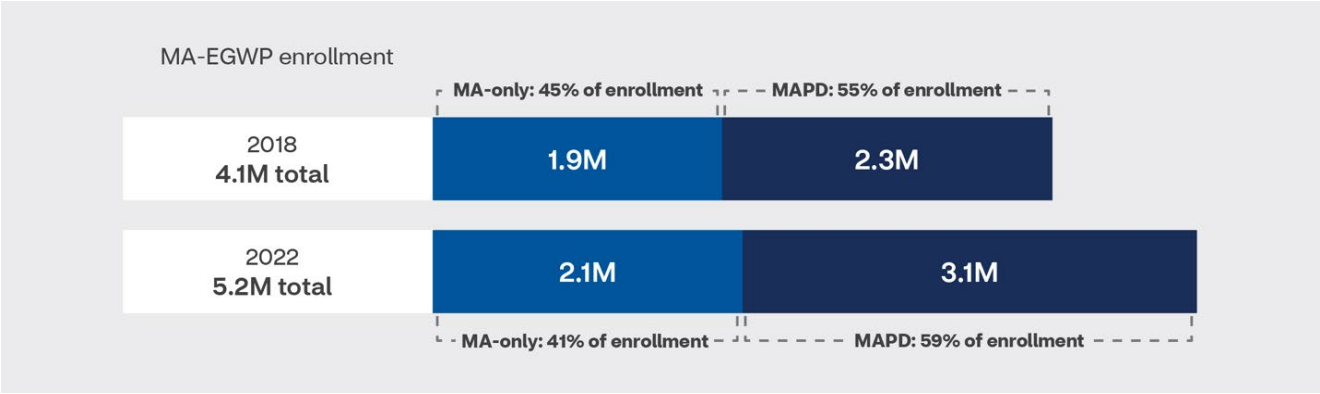
Between 2018 and 2022, total MA-EGWP enrollment increased by nearly 27 percent, from 4.1M to 5.2M (Figure 2).[13] And, MAPD plan enrollment, during this time, grew at a faster rate than MA-only plans.

This growth is due in part to the interest in integrated medical and pharmacy benefits. MAPD-EGWPs allow for immediate data sharing, resulting in accelerated outreach and enhanced clinical engagement. This exchange of information enables the prompt identification and closure of gaps in care, ultimately contributing to the improvement of medication adherence. It is also easier for beneficiaries because they have one ID card to access both medical and pharmacy benefits. This improved engagement and coordination can provide greater cost savings for plan sponsors.

"The evidence is clear that MA plans provide more coordinated, higher quality care which is critical to care for people who are older and have more health conditions."

David Kendall,
Senior Fellow for Health and Fiscal Policy at Third Way

Figure 2: MA-EGWP vs. MAPD-EGWP enrollment, 2018 and 2022[14]



Greater payment stability

CMS provides MA-EGWPs a fixed payment for each beneficiary to cover Parts A and B benefits. The predictability of these payments allows insurers to keep premiums stable and pass cost savings to plan sponsors in the form of sustainable pricing. By leveraging this predictability, MA-EGWPs protect plan sponsors from unforeseen expenses. MA-EGWPs were advantageous in navigating unexpected financial burdens associated with COVID-19, such as unexpected costs associated with the virus and the surge in demand for care.

Star Ratings and risk-adjusted payments, based on population health, can also increase reimbursements. These bonus payments enable MA plans to offer supplemental benefits to members.

Public sector plan sponsors rely on this predictability to provide coverage for retirees. For example, the Teachers' Retirement System of the State of Kentucky (TRS), a comprehensive retirement plan for Kentucky's public-school teachers, was facing rapidly increasing health care costs.

According to Jane Gilbert, Director of Retiree Health Care for TRS, providing coverage through a MA-EGWP has allowed TRS to continue to provide benefits to its members that mimic the Medicare supplement style coverage previously provided. And it does so at a sustainable cost while including valuable supplemental benefits, such as a gym membership, meal delivery after surgery, and telehealth visits.[15]

"When we go through a bid process with a plan sponsor, we match the existing plan that they have and mirror the commercial plan that they had when they were employees. We build a richer plan than they could otherwise get in the individual market. We do all of this and bring the plan sponsor greater stability in their benefits costs."

Rick Frommeyer,
Senior Vice President, Aetna® Group Retiree Solutions

The Inflation Reduction Act (IRA)

The Inflation Reduction Act, signed into law in August of 2022, brings major changes to the Medicare Part D program to help beneficiaries control prescription drug costs. All Medicare Advantage plans that offer Part D pharmacy coverage must meet minimum standards and requirements of the program.

As of January 1, 2023, the IRA implemented $0 copay for all vaccines recommended by the Part D Advisory Committee on Immunization Practices and a $35 monthly OOP cap for insulin. Beginning in 2025, the IRA adds more changes, including:

1. A $2,000 prescription drug plan OOP limit.
2. A new manufacturer discount program will replace the current Medicare Coverage Gap Discount Program (CGDP).
3. The ability for Medicare to negotiate certain Part B and Part D prescription drug prices. Drug manufacturers will now be partially responsible for costs above the catastrophic threshold. Thus, health plans in the catastrophic phase will share liability with the government (Table 2).

Under the new discount program, manufacturers will pay a 10 percent discount for prescriptions before the OOP limit and a 20 percent discount above the OOP limit. Unlike the CGDP, the new discounts apply to both low-income subsidy (LIS) and non-LIS enrollees (the current discount program only applies to non-LIS enrollees). The IRA shifts financial liability for Part D costs from the government to Part D plans, placing plans at greater risk during the catastrophic phase and potentially subjecting them to increased costs.[16]

Trends to watch with IRA Implementation[17]

- **Evolution of the Part D Program:** Changes in premium structures are anticipated, with a significant impact expected, particularly in coinsurance designs.
- **Shifting Financial Landscape:** Adjustments anticipated due to reduced member cost-sharing and federal reinsurance, potentially balanced by measures such as increased direct subsidies and variable pharmaceutical manufacturer payments.
- **Stakeholder Dynamics in Focus:** Variations in member benefits are expected alongside responses from pharmaceutical manufacturers, the federal government, and employer plans to manage shifting payments, reinsurance levels, and plan liabilities.

Employer Group Waiver impacts

One noteworthy distinction in drug coverage between EGWP and individual plans is the average cost-sharing experienced by members. Typically, EGWP beneficiaries encounter lower out-of-pocket (OOP) costs for Part D drugs, leading to a slower progression through the benefits phases compared to individuals.[18] Specifically, only 22 percent of group MA plan enrollees reach the catastrophic phase, whereas 34 percent of individuals do.

Despite these advantages, there is a potential challenge concerning manufacturer discounts for EGWP members due to changes in the discount program. However, a specific provision within the IRA designed for employer plans can help mitigate this disruption.[19]

According to the IRA provision, any enhancements in benefits initiated by an employer or union will contribute to an enrollee's OOP spending. Consequently, enrollees will reach the OOP cap sooner, resulting in a greater proportion of drugs receiving the manufacturer's 20 percent discount in the catastrophic phase. It's important to note, though, that in this scenario, all Part D plans will bear increased financial liability for costs in the catastrophic phase, as opposed to benefiting from reduced reinsurance payments by the government.

Benefits flexibility of MA-EGWP

With MA-EGWPs, employers can tailor benefits that match or exceed Original Medicare. They may also:

- Vary premiums for members living in different regions, while providing the same benefit design nationwide.
- Provide tailored educational materials and more flexible member enrollment.
- Include additional health programs such as diabetes management, caregiver resources or 24-hour nurse help line.

"Our EGWP was already focused on encouraging utilization of telehealth and mail order pharmacy before the pandemic. When the pandemic started, we didn't miss a beat and saw high utilization of telehealth at the peak of the pandemic and continue to see high utilization of mail order pharmacy."

Jane Gilbert,
Teachers' Retirement System of State of Kentucky

For instance, among its many health programs, the School Employees Retirement System of Ohio through its MA-EGWP offers a free 24/7 nurse line; a fitness and wellness program through Silver Sneakers; and a Resources for Living program that enables members to navigate and connect with a wide range of community services, including personal care, housekeeping, and caregiver relief.

Additionally, these flexibilities allow MA plans to adapt to meet members' evolving health care needs. During the pandemic, CMS and health plans were faced with vaccine hesitancy from beneficiaries, with about 40 percent uncertain about getting COVID-19 vaccines.[20]. Plans were able to quickly develop campaigns to help

members navigate the new landscape, from getting vaccines to accessing care. By December 2021, 82.2 percent of all Medicare beneficiaries had their primary COVID-19 vaccine.[21] Telehealth is another example where plan sponsors adapted to changing needs. Many MA-EGWPs waived or reduced cost sharing for virtual services during the public health emergency. Not only could members access care from any location, but one in four sought mental health care remotely as people faced increased anxiety and depression.[22]

"A retiree medical benefit offered through an employer is going to be seen as a trusted institution. That means they have an opportunity to dispel myths and rumors."

James Gelfand,
Employee Retirement Income Security Act (ERISA)
Industry Committee

Health equity and addressing social risk factors

Health equity is increasingly becoming a core tenant of the broader MA program. Over the past few years, policymakers have been collaborating with key stakeholders to assess current strategies, with the goal of identifying necessary policy changes to reduce disparities and meet members' social needs.

In 2022, CMS asked for stakeholder or public comments on the future of the MA program to look for input on strategies to strengthen and create more opportunities for engagement on topics like:

- Advancing Health Equity
- Expanding Access
- Driving Innovation to Promote Person-Centered Care
- Supporting Affordability and Sustainability[23]

In CMS's 2024 MA and Part D Final Rule, the agency added a health equity index to the Star Ratings system to help address disparities in care. They will now reward plans that are able to reach high scores for enrollees with social risk factors.[24]

Additionally, as policymakers continue to consider actions to advance health equity, many MA plans are already using existing mechanisms to target better solutions for members' needs. For example, plans are designing benefits to support those with specific chronic conditions who may be at high risk. CMS notes, "MA plans increasingly offer supplemental benefits that address social determinants of health."[25] Insurers are working closely with providers, plan sponsors and other stakeholders to pursue innovative strategies for tackling health disparities.

Conclusion

Medicare Advantage usage by plan sponsors is growing, with more than half of retirees being offered an MA-EGWP option. Overall, by 2033, 62 percent of all beneficiaries will be enrolled in MA rather than Original Medicare.[26]

MA-EGWPs offer high-quality plans with stable and predictable costs, which is important to both plan sponsors and retirees. These plans have higher-than-average Star Ratings[27] and a majority of members report high satisfaction. They often include more programs in the form of supplemental benefits, and members with high-cost and chronic conditions are protected from high out-of-pocket expenses.

Policymakers continue to refine plans to address the long-term affordability and funding of Medicare. Additionally for Medicare Advantage plans, they are focused on prescription drug changes, payment policy practices, and reducing health disparities.

Acknowledging CMS's phase-in of a new risk adjustment model for the Medicare Advantage program, it is anticipated that changes may adversely impact MA-EGWPs, given the relatively higher acuity levels of beneficiaries in MA-EGWPs compared to the broader MA population. Additional research and analysis on these shifts will be necessary as the model continues its rollout over the coming years.

Changes affecting the stability of the market for plans' ability to offer supplemental benefits and keep OOP costs low could impact beneficiaries' access and outcomes. Given the sizable role MA-EGWPs play in retiree benefits for public sector purchasers, and the limited information available within this critical segment of the American workforce, further research is needed to help policymakers understand the role MA-EGWPs currently play and potential impacts of proposed policy changes to MA-EGWPs.

References

[1] Kaiser Family Foundation. Medicare Advantage in 2023: Enrollment Update and Key Trends. August 9, 2023. Available at: https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2023-enrollment-update-and-key-trends/

[2] Ibid.

[3] The Board of Trustees. 2022 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds. June 2, 2022. Available at: https://www.cms.gov/files/document/2022-medicare-trustees-report.pdf

[4] Analysis using enrollment data released by the Centers for Medicare & Medicaid Services. The analysis uses enrollment files released in February of each year, from 2018 through 2022, reflecting enrollment effective in January of each respective year.

[5] MedPAC. Report to Congress: Medicare Payment Policy. March 2023. Available at: https://www.medpac.gov/wp-content/uploads/2023/03/Mar23_MedPAC_Report_To_Congress_SEC.pdf

[6] Better Medicare Alliance. Poll: A bipartisan majority of seniors on Medicare Advantage are satisfied with their coverage. February 22, 2023. Available at: https://bettermedicarealliance.org/news/poll-a-bipartisan-majority-of-seniors-on-medicare-advantage-are-satisfied-with-their-coverage/

[7] Kaiser Family Foundation. Medicare Advantage in 2023: Enrollment Update and Key Trends. August 9, 2023. Available at: https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2023-enrollment-update-and-key-trends/

[8] Bureau of Labor Statistics. Occupational Employment and Wages in State and Local Government. December 2021. Available at: https://www.bls.gov/spotlight/2021/occupational-employment-and-wages-in-state-and-local-government/home.htm

[9] Evernorth Health Services. Maintaining High-Quality, Affordable Employer-Based Medicare Coverage. August 10, 2021. Available at: https://www.evernorth.com/articles/understanding-employee-group-waiver-plans

[10] Kaiser Family Foundation. Spending on Medicare Advantage Quality Bonus Program Payment Reached $10 Billion in 2022. August 25, 2022. Available at: https://www.kff.org/medicare/issue-brief/spending-on-medicare-advantage-quality-bonus-program-payment-reached-10-billion-in-2022/

[11] Analysis using enrollment data released in February 2020 by the Centers for Medicare & Medicaid Services; MedPAC March 2020 Report to Congress. Available at: https://www.medpac.gov/document/http-www-medpac-gov-docs-default-source-reports-mar20_entirereport_sec-pdf/

[12] Ibid.

[13] Analysis using enrollment data released by the Centers for Medicare & Medicaid Services. The analysis uses enrollment files released in February of each year, from 2018 through 2022, reflecting enrollment effective in January of each respective year.

[14] Ibid.

[15] Better Medicare Alliance. Medicare Advantage Is How We Say "Thank You" to Our Kentucky Retired Teacher Heroes. April 20, 2021. Available at: https://bettermedicarealliance.org/blog-posts/medicare-advantage-is-how-we-say-thank-you-to-our-kentucky-retired-teacher-heroes/

[16] Congress. H.R.5376-Inflation Reduction Act of 2022. Available at: https://www.congress.gov/bill/117th-congress/house-bill/5376/text

[17] Milliman. 2025 Financial Impacts for Part D Employer Group Waiver Plans (EGWPs). Available at: https://www.milliman.com/-/media/milliman/pdfs/2024-articles/1-22-24_2025-financial-impacts-for-part-d-egwps.ashx

[18]Avalere Health. Utilization and Spending by Medicare Beneficiaries in Employer Part D. June 1, 2020. Available at https://avalere.com/insights/utilization-and-spending-by-medicare-beneficiaries-in-employer-part-d

[19] Ibid.

[20] Journal of Community Health. Poghosyan, Hermine et al. November 25. 2022. COVID-19 Vaccine Hesitancy Among Medicare Beneficiaries with and without Cancer History: A US Population-based Study. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9702715/

[21] ASPE. Samson, Lok Wong et al. October 2022. Reductions in Deaths and Hospitalizations Associated with COVID-19 Vaccinations Among Medicare Beneficiaries: Full Year 2021 Estimates. Available at: https://aspe.hhs.gov/sites/default/files/documents/21a637373ccaf4c66f934bdbbb23ad5c/covid-19-medicare-2021-lives-saved.pdf

[22] Kaiser Family Foundation. Koma, Wyatt et al. FAQs on Medicare Coverage of Telehealth. May 23, 2022. Available at: https://www.kff.org/medicare/issue-brief/faqs-on-medicare-coverage-of-telehealth/

[23] CMS. Medicare Program; Request for Information on Medicare. Aug 2022. Available at: https://www.federalregister.gov/documents/2022/08/01/2022-16463/medicare-program-request-for-information-on-medicare

[24] Federal Register. December 27, 2022. Medicare Program; Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, Medicare Parts A, B, C, and D Overpayment Provisions of the Affordable Care Act and Programs of All-Inclusive Care for the Elderly; Health Information Technology Standards and Implementation Specifications. Available at https://www.federalregister.gov/documents/2022/12/27/2022-26956/medicare-program-contract-year-2024-policy-and-technical-changes-to-the-medicare-advantage-program

[25] CMS. CY 2023 MA and Part D Final Rule. May 9, 2022. Available at: https://www.federalregister.gov/documents/2022/05/09/2022-09375/medicare-program-contract-year-2023-policy-and-technical-changes-to-the-medicare-advantage-and

[26] Kaiser Family Foundation. Medicare Advantage in 2023: Enrollment Update and Key Trends. August 09, 2023. Available at: https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2023-enrollment-update-and-key-trends/

[27] Ibid.

Contact Us

National Institute for Public Employee Health Care Policy

601 Massachusetts Avenue Suite 520W Washington, DC 20001

Email: admin@healthcarepolicy-institute.org

NATIONAL INSTITUTE FOR
PUBLIC EMPLOYEE
HEALTH CARE POLICY