

A PUBLIC POLICY PRACTICE NOTE

**Draft**

Medicare Advantage Plan  
Cost Projections for Retiree Group  
Health Benefit Valuations

*April 2025*

Developed by the MA Cost Projections Practice Note Work  
Group of the American Academy of Actuaries

## MA COST PROJECTIONS PRACTICE NOTE – DRAFT

The American Academy of Actuaries' Health Practice Council has drafted a practice note, *Medicare Advantage Plan Cost Projections for Retiree Group Health Benefit Valuations*, which is intended to offer some practical applications for practitioners as they develop Medicare Advantage (MA) cost projections.

In an effort to ensure that the practice note offers perspectives from those currently responsible for such projections, we are soliciting feedback on the current draft, along with responses to the following:

1. Are there any significant approaches to estimating future costs, or assisting development of a retiree health valuation, of MA health plan benefits that are missing or should be included in the current language within the draft practice note?
2. Are there other MA plan cost projections that you would like to see addressed in additional illustrations?
3. The key inputs to this draft's illustrations are paid claims, Centers for Medicare and Medicaid Services (CMS) funding levels, and the insurer's target loss ratios. Are there other funding elements that you have found to be readily accessible from carriers to reflect in projections of MA plan costs that might be helpful to include in the practice note?

The comment deadline for comments on this draft is **June 30, 2025**. Please send your comments and feedback to the Academy's policy project manager for health, Matthew Williams ([williams@actuary.org](mailto:williams@actuary.org)).

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## I. INTRODUCTION

The purpose of this practice note is to provide information and support for actuaries in their determination of how to project the cost of Medicare Advantage (MA) products as part of a valuation for a retiree group health benefit plan (also called an Other Post-Employment Benefit or “OPEB” plan) which covers Medicare-eligible retirees.<sup>1</sup> Specifically, this practice note addresses the cost components that underlie MA plans, how such components can be combined with certain assumptions to model future MA plan costs, and where to find the data to make regular updates to an MA cost projection model. One particular goal is to provide actuaries with tools to project costs for an MA plan that currently has a zero-dollar premium.

This practice note is not a promulgation of the Actuarial Standards Board (ASB), is not an Actuarial Standard of Practice (ASOP), is not binding upon any actuary, and is not a definitive statement as to what constitutes generally accepted practice in the area under discussion. Events occurring subsequent to the publication of this practice note may render the practices described herein irrelevant or obsolete. Note that ASOP No. 6, *Measuring Retiree Group Benefits Obligations and Determining Retiree Group Benefits Program Periodic Costs or Actuarially Determined Contributions*,<sup>2</sup> provides current professional standards for actuaries practicing in the area of retiree health benefit plan valuations in every sector (corporate, multiemployer, and public). All OPEB actuaries are therefore encouraged to review the latest version of ASOP No. 6 and refer to the Applicability Guidelines<sup>3</sup> as a resource to suggest which other ASOPs provide guidance.

This practice note was prepared by and reflects the views of the MA Cost Projection Practice Note Work Group, Retiree Benefits Committee, of the American Academy of Actuaries (Work Group). The Work Group makes no representation of completeness, as other approaches may also be in use and applied. Each actuary should consider the facts and circumstances specific to their particular situation and how the information provided in this practice note may inform their thinking. Note that any references to laws, regulations, or public data may become outdated if those items are revised after the publication of this practice note. The Work Group thanks Jennifer Leming, Paul Koch, Dan Callahan, and Bob Jablonowski for their thoughtful review of this practice note. The Work Group would also like to thank the staff of the Centers for Medicare and Medicaid Services (CMS) Office of the Actuary (OACT) for their expertise and perspectives on the pricing of MA plans.

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<sup>1</sup> Due to significant Medicare Part D drug benefit changes in the Inflation Reduction Act and timing of the related CMS guidance, Medicare Part D plans have not been covered in this practice note. A separate practice note on Medicare Part D plans is intended for the future. For a historical review of Medicare Advantage and Part D plans, refer to Appendix A.

<sup>2</sup> The latest version of ASOP No. 6 can be found at <http://www.actuarialstandardsboard.org/standards-of-practice/>.

<sup>3</sup> The Applicability Guidelines may be accessed at <http://www.actuary.org/content/applicability-guidelines-actuarial-standards-practice-0>.

## II. DEFINITIONS

**Individual Risk Score** is a measure used by the CMS to adjust payments to MA and Part D (PD) plans to account for differences in health status and thereby the expected costs among plan enrollees. Each individual's score is determined by a CMS model which differs between MA versus PD, and which uses a combination of factors including age, sex, Medicaid eligibility, disability status at initial Medicare enrollment, whether the individual resides in an institution, and diagnosis codes related to various disease categories. Such scores are normalized so that the average score for the overall national fee-for-service Medicare population is 1.0. Note that “plan average risk score” is the average of the Individual Risk Scores for enrollees in a given MA/PD plan.

**CMS MA Plan Star Ratings** are CMS-published performance scores which aim to measure the quality of health services received by consumers enrolled in MA plans. The plans are rated on a scale of one to five stars, with a five-star rating being the highest score. Such ratings are highly visible to the public and provide consumers with a means for comparing MA plans available to them. The ratings also impact the level of funding that a plan receives from CMS. Plans are rated based on a variety of measures, where the number of measures considered varies by whether it is for an MA, Part D, or MA/PD contract. The measures used and the weighting system applied to each measure are subject to change annually and are announced in April for the following year.

**Original Medicare** consists of the components of Medicare that have existed since the program's inception in 1965, specifically Part A (for hospital coverage) and Part B (for other medical care).

### III. KEY COST COMPONENTS OF MA PLAN FINANCIALS

This section first describes the basic types of MA plans in the marketplace, then discusses the major components of costs and revenue associated with MA plans. Towards the end of this section is an illustration of how these components fit together to yield the MA premium charged to plan sponsors and/or beneficiaries.

#### *Medicare Advantage Plan Types*

There are two broad categories of MA plans: individual plans and group plans. Individual plans are those offered via the individual marketplace and are open to anyone eligible to enroll in MA. Individual plans are generally network-based Health Maintenance Organization (HMO) plans or benefit-differential Preferred Provider Organization (PPO) plans (which feature explicit differences in cost-sharing for network versus non-network utilization). Both types of individual plans also typically impose compulsory care management.

Unlike individual plans, group MA plans are restricted to individuals eligible for a plan sponsor's group benefit plan. These plans can also be network-based HMOs or benefit-differential PPOs, but typically they are open-access PPOs with no benefit or cost-sharing differential for services received in-network versus out-of-network. Unlike with individual plans, the care management programs of group plans are often voluntary. Also, the required out-of-pocket (OOP) cost-sharing for group plans tends to be lower than for individual market plans in most geographic areas. These plans are facilitated through a CMS waiver process which allows coverage to be provided on a national basis, and allows the plan sponsor to restrict enrollment to the plan sponsor's participants.

The next few subsections introduce the main components of the financials for MA plans: CMS funding, paid claims, and premiums. While these components can be applied to both group and individual MA plans, this practice note will focus primarily on projecting costs for *group* MA plans. Accordingly, the discussions and illustrations contained in this note will tacitly assume that a group MA plan is under consideration by the actuary. The main reason for this is that the majority of situations where an actuary is considering projecting MA plan costs for an OPEB valuation will be for a group MA plan. Retiree medical benefit plans that provide coverage through the individual market typically, but not always, involve an employer Health Reimbursement Arrangement (HRA) that the participants use to purchase coverage on the individual market. In such cases, the basis of the employer's OPEB liability is limited to their HRA contribution amounts and so a projection of future individual MA premium increases may not be required. In the rare valuations when a projection of individual MA premiums is needed (either because such premiums plus allowed expenses are lower than the HRA contribution maximum, or the plan subsidy references such premiums without limitation), the actuary will likely not have access to the individual MA plan financials needed for the framework presented in this practice note. Part V of this practice note addresses situations where the data required for the framework is not available and other challenges unique to the individual MA plan market.

### ***CMS Medicare Advantage Funding***

CMS provides a capitated monthly subsidy to the MA carrier for each MA plan enrollee. Under current law, subsidies are effectively targeted at the expected cost of providing benefits that are equivalent to Medicare Parts A and B for each individual enrollee. This is achieved by adjusting a county-specific baseline subsidy (resulting from the bid process described below) for each enrollee's age, health conditions, and other applicable factors through the application of **Individual Risk Scores**. Additionally, MA plans that have a **CMS MA Plan Star Rating** of four stars or higher receive a funding increase of up to 5% (or 10% in certain counties). Determination of the CMS funding at the member level is a highly complex process with many intertwined details.<sup>4</sup>

Individual MA plans are required to submit annual “bids” to CMS. Such bids contain detailed information about the MA plan including plan provisions, service area, and actuarial pricing. They must be reviewed and approved by CMS in advance of the plan's offering for each year that the plan is offered. Annually, CMS establishes a benchmark in each county (tied to **Original Medicare** spending) that represents the maximum payment to MA plans. If a plan bids higher than this benchmark, beneficiaries will be required to pay higher premiums if they enroll in that plan. This encourages more aggressive bidding by plans. If a plan bids below their corresponding benchmark, then such plan is paid their bid amount plus a rebate (i.e., a portion of the difference between their bid and the benchmark). The higher a plan's **CMS MA Plan Star Rating**, the higher the proportion paid as a rebate. Insurers then use any rebates to provide enhanced benefits (such as dental, vision, and/or hearing coverage) or to lower the beneficiary cost-share.<sup>5</sup>

Conversely, group MA plans do not submit bids to CMS. Rather, CMS funding for group plans is based on the average bids across all individual plans in the corresponding geographic area, with rebates paid in the same manner as described above for individual plans. Because the results of the individual MA plan bidding process are not known until August, the bid-to-benchmark ratios used to set group MA plan funding as described herein are based on the average bids from the preceding year. For example, the average bid-to-benchmark ratios from the individual plan bids submitted in 2022 (for the 2023 individual plan year) are used to establish the 2024 funding baseline for group MA plans. For both group and individual MA plans, CMS funding can be expressed on an average Per Member Per Month (PMPM) basis, similar to claims costs.

Note that while some MA plans also offer drug benefits under Part D (making them MA/PD plans), CMS funding for the Part D portion of benefits is separate from that for the MA portion, and the funding amount for Part D is determined by a totally different set of parameters than used for MA.

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<sup>4</sup> The details of determining CMS subsidy funding at the member level are beyond the scope of this practice note, as the funding will be reported by the insurer and not determined by the OPEB actuary themselves.

<sup>5</sup> For more detail on how CMS MA funding is determined for the individual market, see the following MedPAC article: <https://www.medpac.gov/document/medicare-advantage-program-payment-system/>.

### ***Paid Claims***

This represents the claims paid by the MA plan for the plan participants, often expressed on a PMPM basis. Many group carriers will also include “claims expenses” in their definition of paid claims, where such expenses capture the direct cost of specific condition-management programs that are intended to impact claims.

### ***MA Premium***

This is the premium rate charged by the MA plan insurer for the member’s coverage, regardless of whether it is paid by the member or the plan sponsor, or shared in some manner.

### ***Loss Ratio***

This equals paid claims divided by total revenue, where revenue typically consists of CMS funding plus MA premiums.

### ***Gainshare***

For certain group MA plans, this represents the amount paid from the insurer back to the group plan sponsor, if applicable under their contractual arrangement. Gainshare is typically determined several months after the end of the plan year, once the total claims and CMS funding have been finalized for the plan year. If applicable under a particular contractual arrangement, this represents the portion of insurer profits to be shared with the plan sponsor in case the MA plan performs at specified target levels. Generally, gainshare funds received by the plan sponsor must be used to offset the sponsor’s premiums paid or medical/drug benefit costs for the MA participants. Gainshare contractual arrangements are typically seen only for very large group MA plans (e.g., plans with over 10,000 lives covered).

### ***Illustration of MA Plan Financials***

The following illustration shows how each of the components can be fit together to form a framework for modelling current and future MA plan costs. This framework will be used in subsequent sections to illustrate how changes in the components can result in changes to the bottom-line premium charged by the insurer (i.e., the MA premium).

(A) Paid claims	\$ 1,050
(B) CMS funding	\$ 1,200
(C) MA premium	<u>50</u>
(D) Total revenues = (B) + (C)	\$ 1,250
(E) Loss ratio = (A) / (D)	84.0%
(F) Gainshare payable	\$ 37.50



In the above table, paid claims for the year were \$1,050 PMPM. Total CMS funding paid to the insurer was \$1,200 PMPM, and the insurer charged the plan sponsor \$50 PMPM, for total insurer revenues of \$1,250 PMPM. The resulting loss ratio is  $\$1,050/\$1,250 = 84\%$ . If there is a gainshare agreement, the amount of any gainshare payable is typically determined after the end of the year, and depends upon the plan sponsor’s contractual arrangement with the insurer. In the above example, it is assumed the contractual arrangement is that the insurer will share 50% of the profits with the plan sponsor, to the extent the loss ratio is below 90%. The gainshare payable of \$37.50 is therefore determined as  $(90\%-84\%) \times \$1,250 \times 50\%$ .

This framework can be used to illustrate a variety of situations. A common situation is when a plan sponsor moves to an MA plan for the first time and has a three-year contract with an insurer where the premiums are set in advance for the three years. While the premium may be the same (or similar) for the entire period, the insurer’s profitability in this situation will often vary substantially by year. This is because CMS funding for a new plan is often significantly lower in the initial years as the insurer implements its various programs to obtain the proper diagnoses and associated risk coding to get a better risk profile of the covered population. As that risk coding improves, the CMS funding quickly increases to more stable levels (i.e., there is a “select and ultimate period” for risk-scoring impact). This is illustrated in the below table and assumes no gainshare for sake of simplicity.

	<u>Year 1 (2021)</u>	<u>Year 2 (2022)</u>	<u>Year 3 (2023)</u>	<u>3-Year Average</u>
(A) Paid claims	\$ 1,051	\$ 1,098	\$ 1,147	\$ 1,099
(B) CMS funding	\$ 1,000	\$ 1,150	\$ 1,242	\$ 1,131
(C) MA premium	<u>90</u>	<u>90</u>	<u>90</u>	<u>90</u>
(D) Total revenues = (B)+(C)	\$ 1,090	\$ 1,240	\$ 1,332	\$ 1,221
(E) Loss ratio = (A) / (D)	96.4%	88.5%	86.1%	90.0%

In the above table, paid claims increase at an assumed 4.5% per year. CMS funding is assumed to increase 15% from year one to year two, and 8% from year two to year three. These increases on CMS funding are higher than what one would expect for a mature MA plan, but are not atypical for a plan that is implementing MA in year one. The plan sponsor premium is \$90 PMPM for all three years, per the contract with the insurer.

The resulting loss ratio in the initial year is 96.4%. Total revenues exceed total claims, but the insurer may not be profitable in this year as the revenue may not be sufficient to cover its administrative and other costs. The 96.4% loss ratio is not sustainable. By year two, because the CMS funding increase outpaced the claims increase, the loss ratio reduces to 88.5%, restoring profitability. By year three, the loss ratio further reduces to 86.1%, making the plan even more profitable for the insurer. Viewed in total across the three years, the average loss ratio is 90.0%,

which is profitable for the insurer for the block of business. While the premium was stable for all three years, there were significant movements “behind the scenes” that tell a very different story.

A crucial question for OPEB valuation actuaries is what happens after year three, beyond the contract period. Absent the information shown in the above table, the actuaries are only aware that the \$90 premium is guaranteed for three years, and that they will need to project those premium costs into the long-term for an OPEB valuation. Such projections will be addressed in Part IV of this practice note.

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## IV. MA PLAN COST PROJECTION ASSUMPTIONS AND METHODS<sup>6</sup>

### *Framework Introduction*

The example at the end of Section III illustrates a sample three-year period with a contractually guaranteed insurer MA premium, where the context is that the year is 2020, that this is a new MA plan, and that the insurer provided the estimated claims plus the assumed CMS funding for 2021 to 2023. Expanding on that example, say that the actuary who performs an OPEB valuation for the employer sponsor of the MA plan seeks to project MA premiums into future years beyond the contract period, since the premium is the basis of the employer's OPEB liability (less any applicable retiree contributions). If all the actuary considers is the \$90 premium for the first three years, the actuary would probably be inclined to just apply an assumed trend rate to the premium itself. However, the actuary could use the additional information provided by the insurer regarding the projected claims, CMS funding, and resulting loss ratio to refine their cost projection methodology so as to take each of these components into account. Rather than applying an assumed trend on the premiums, the actuary would instead apply assumed trends on the claims and CMS funding. Along with an assumption on the future loss ratio required by the insurer, the actuary would then derive the resulting expected MA premium for each future year, coding the resulting trend on the MA premiums into their valuation system.

This more refined method is shown in the below Illustration 4.1, where the MA premium for 2024 onwards is computed as:  $\{[\text{paid claims}] / [\text{assumed loss ratio}]\} - [\text{CMS funding}]$ . In this example, the actuary applied an assumed 4.5% trend to both the claims and CMS funding, and assumed that future loss ratios would be 90.0%, which is equal to the historical three-year loss ratio over the contract period.

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<sup>6</sup> Note that all illustration figures are unrounded, so that the totals and percentages shown may be different than they would be with rounded figures.

#### Illustration 4.1 (New MA Plan)

		Provided by Insurer							
		<u>2021</u>	<u>2022</u>	<u>2023</u>	<u>2024</u>	<u>2025</u>	<u>2026</u>	<u>2027</u>	<u>2028</u>
(A)	Paid claims	\$1,051	\$1,098	\$1,148	\$1,199	\$1,253	\$1,310	\$1,369	\$1,430
(B)	CMS funding	\$1,000	\$1,150	\$1,242	\$1,298	\$1,356	\$1,417	\$1,481	\$1,548
(C)	MA premium	<u>90</u>	<u>90</u>	<u>90</u>	<u>35</u>	<u>36</u>	<u>38</u>	<u>40</u>	<u>41</u>
(D)	Total revenues	\$1,090	\$1,240	\$1,332	\$1,333	\$1,393	\$1,455	\$1,521	\$1,589
(E)	Loss ratio = (A) / (D)	96.4%	88.5%	86.2%	90.0%	90.0%	90.0%	90.0%	90.0%
Three-year loss ratio:		90.0%							

A modified version of the framework may also be applicable in situations where the employer has a practice of contracting with an MA insurer on a three-year basis with a constant MA premium in each contract period. In such a situation, the actual MA premium would only change every three years, coinciding with the contractual period rather than every year. An actuary may choose to reflect this dynamic by first projecting a different MA premium using the framework as normal, then determining an equivalent MA premium over each three-year period that yields the same loss ratio over each period. For example, in Illustration 4.1 above, given the assumed loss ratio is 90.0% for 2024 through 2026, the actuary could reflect the average MA premium of \$36 (which is the average of the unrounded amounts in the illustration) rather than the year-by-year amounts in that period. The actuary would then need to do the same for each successive three-year period.

For the sake of consistency and simplicity, in all of the illustrations in Part IV of this practice note, the alternative frameworks described in this subsection will *not* be used. Instead, the framework introduced at the start of Part IV (i.e., the framework applying assumptions on claims, CMS funding, and loss ratio) will be used to derive the resulting expected MA premiums.

## ***Current Practice***

Members of this Practice Note Work Group acknowledge that current practice for most actuaries is to simply apply an assumed trend rate directly to the MA premiums. As can be inferred in Illustration 4.1 for the years 2025 and later, this is equivalent to applying that same trend rate to both paid claims and CMS funding, with a constant loss ratio that supports the premium in the initial projected year.

In many situations, this simplified method of projecting MA premiums may be appropriate. It inherently assumes the MA plan's financials and the broader MA market are in "equilibrium." In other words, it assumes that the current claims, CMS funding, and loss ratios are stable in the long term. It also assumes that the current premium is representative of a reasonable loss ratio given current claims and revenues. In many cases, premiums may have been set in the past with what is now outdated information, particularly in the case of multi-year rate guarantees, in which case actuaries may want to consider pursuing updated information regarding the plan financials and adjusting their short-term assumptions accordingly.

## ***Assumptions on Key Framework Components***

This subsection contains information and considerations regarding each of the three framework components that may be relevant to the actuary when developing assumptions to project future MA premiums using the framework.

### **Paid Claims**

This component should be most familiar to the actuary, since many OPEB valuations involve trending per capita claims costs into the future. However, there are some key considerations that are specific to paid claims for MA plans.

- The allowed costs paid to the providers are typically based on the Medicare Fee Schedule, and thus the prices are controlled by CMS. This is in contrast to pre-65 paid claims, where the prices are not regulated by the government. As a result, paid claims under MA plans tend to increase at a lower rate than for pre-65 plans.
- Unlike post-65 retiree medical plans that involve traditional Medicare integration, the claims paid are not reduced by CMS payments. With traditional Medicare integration, Medicare pays a portion of each claim according to the coverage in Medicare Parts A and B, and therefore the reported claims payments are net of the portion that Medicare pays. Medicare does not pay any portion of claims incurred in a MA plan, as the responsibility for claims payment and risk are transferred to the MA carrier. Therefore, the claims amounts are much higher than fee-for-service Medicare with traditional Medicare integration. This also means that there is a much higher requirement for claims to be fully credible, more akin to pre-65 claims in this regard.

- In practice (and assuming credibility issues have been resolved), paid claims tend to trend at a rate similar to those under Medigap (also known as Medicare Supplemental) or traditional Medicare integration plans. Trend survey information specific to these types of plans might be a good source of information when determining an assumption for MA claims trend.

### CMS Funding

Unlike with paid claims, most OPEB actuaries likely will not be able to independently develop a trend assumption for CMS funding. The rules and considerations that drive CMS funding are complicated, and the actuary almost certainly would not have the information and resources needed to determine expected CMS funding by themselves.

In practice, the assumed trend on CMS funding can be set relative to the assumed trend on claims. Absent any specific information to the contrary, the actuary may decide to assume that CMS funding and claims would trend in the future at the same rate. In a discussion with representatives from the OACT at CMS, the representatives pointed out that a major component of CMS funding increases for MA plans is related to increases on claims in **Original Medicare** (as well as increases on other outlays to providers). The representatives also stated that in their view it would be reasonable to assume that total CMS funding increases will generally keep pace with MA claims increases going forward.<sup>7</sup>

Note that if the actuary assumes that CMS funding trend is significantly lower than claims trend on a sustained basis, then the resulting MA premiums would increase at a pace that would not be sustainable in the marketplace. Individual market MA plans and group MA plans alike would be affected by this phenomenon, and the MA market would eventually collapse. Assuming that CMS funding increases align with claims increases in the long term, it is therefore akin to assuming that the MA marketplace is in long-term equilibrium.

That being said, there are situations where in the short term the actuary may decide to trend CMS funding differently than claims. The illustration at the beginning of this section is one example, where the CMS funding increases at a much higher rate than claims because the MA plan is new and the CMS funding levels are ramping up to normal levels. Another such example is when CMS implements reforms that introduce a “shock to the system,” such as the reforms reflected in the final version of the 2024 *Announcement of Calendar Year Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies* (“Final Notice”)<sup>8</sup> that are to be phased in from 2024 to 2026. An illustration on how this situation might be handled is provided later in this section.

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<sup>7</sup> Note that CMS representatives’ view was primarily regarding the overall MA market, not specifically group MA plans.

<sup>8</sup> Each year, CMS publishes an advance notice and a final notice that dictate various matters relevant to MA and Part D plans, including rules that pertain to funding levels for the coming year(s). The Final Notice (which is also known as the *Medicare Advantage and Part D Rate Announcement*) for 2024 can be viewed at <https://www.cms.gov/files/document/2024-announcement-pdf.pdf>.

Note that some actuaries are of the opinion that for group MA plans, CMS funding increases may fall short of paid claims increases beyond the 2024-2026 phase-in period of CMS funding reform. This matter is discussed further in Appendix C.

### Loss Ratio

The loss ratio is the third component used in our framework. This metric identifies what percentage of the MA insurer's total revenues are used to pay the group's claims. Typical loss ratios are in the range of 85% to 95%.

Typically, one might assume that administrative expenses (that is, non-claim expenses) are in the range of 4%-6% of total revenues with larger (smaller) groups being towards the lower (higher) end of the range. An assumption for administrative expenses of 4%, when paired with a 90% loss ratio, for example, implies that a profit/risk margin of 6% will result for the insurer. Such a profit/risk margin for the insurer, in practice, is generally acceptable to the insurer. Note that the larger the group, the higher the MA insurer's tolerance will be for a lower profit/risk margin (i.e. for a loss ratio of greater than 90%).

The group MA market has grown substantially over the past decade. The insurers that dominate in the MA market now have far more experience and data to use when projecting claims and revenue for pricing purposes. Recognizing the highly competitive nature of the group MA marketplace and layering in the fact that insurers in this space now have the luxury of historical data, it is typical for insurers to be willing to accept higher loss ratios in order to obtain or retain group business. For very large groups (i.e., 25,000+ members), loss ratios as high as 92%-94% targeted by the insurer are not atypical. Such loss ratios result from the competition in the group MA marketplace and imply lower administrative cost assumptions as well as lower profit/risk margins.

As actual plan experience emerges with each experience period, the actuary will have a better, data-supported view of the contract's loss ratio for recent periods. The actuary can utilize the historical loss ratios to select a prospective loss ratio assumption that models the client's best estimate for future contract periods, considering the current and future state of the group MA marketplace.

At the beginning of this subsection on loss ratios, a 90% loss ratio was referenced. In practice, loss ratios vary significantly, especially for smaller groups where actual claims are more likely to vary significantly higher or lower than expected in some years. As noted above, a loss ratio that is greater than 90% is often used for larger groups. Conversely, MA premiums for smaller groups are typically developed assuming the loss ratio is lower, and a ratio in the 85% to 90% range is often used.

It is also important to recognize that ranges for loss ratios will vary by insurer. A going-to-market exercise such as a request for proposal (RFP) may also cause an insurer to assume higher loss ratios (or to remove conservatism from their projected claims / CMS funding) in order to either keep an existing employer contract or to "buy the business" to win a new employer group contract.



## Additional Framework Illustrations

This subsection applies the above concepts to a variety of situations. Each case shown below will outline the setting in which the actuary is operating, illustrate how the actuary applies the framework, then discuss the underlying assumptions and considerations.

### Illustration 4.2 (MA Plan in Equilibrium)

Setting: The year is 2023. The actuary's client has a three-year insured arrangement for 2021-2023 with a \$100 MA premium. This is not a new MA plan, and the insurer has reported the actual plan financial information for 2020-2022. The MA premium for 2020 was \$140, from a previous contract. The actuary knows the 2023 premium since it is within the three-year contractual arrangement, but seeks to project that premium beyond 2023 for an upcoming OPEB valuation using the historical information for the plan.

		Premium Guarantee								
		Known History								
		<u>2020</u>	<u>2021</u>	<u>2022</u>	<u>2023</u>	<u>2024</u>	<u>2025</u>	<u>2026</u>	<u>2027</u>	<u>2028</u>
(A)	Paid claims	\$1,150	\$1,204	\$1,256	\$1,313	\$1,372	\$1,433	\$1,498	\$1,565	\$1,636
(B)	CMS funding	\$1,175	\$1,238	\$1,302	\$1,361	\$1,422	\$1,486	\$1,553	\$1,623	\$1,696
(C)	MA premium	<u>140</u>	<u>100</u>	<u>100</u>	<u>100</u>	<u>119</u>	<u>125</u>	<u>130</u>	<u>136</u>	<u>142</u>
(D)	Total revenues	\$1,315	\$1,338	\$1,402	\$1,461	\$1,541	\$1,610	\$1,683	\$1,759	\$1,838
(E)	Loss ratio = (A) / (D)	87.5%	90.0%	89.6%	89.9%	89.0%	89.0%	89.0%	89.0%	89.0%
Three-year loss ratio:		89.0%								
		Actuarial Assumptions								
Trend on claims paid		4.7% <sup>9</sup>	4.3%	4.5%	4.5%	4.5%	4.5%	4.5%	4.5%	4.5%
Trend on CMS funding		5.4%	5.1%	4.5%	4.5%	4.5%	4.5%	4.5%	4.5%	4.5%
Assumed loss ratio		N/A	89.0%	89.0%	89.0%	89.0%	89.0%	89.0%	89.0%	89.0%
Resulting trend on MA premium					19.3%	4.5%	4.5%	4.5%	4.5%	4.5%

The historical claims trend for 2021-2022 averaged 4.5%, which is in the range the actuary would normally expect, so the actuary decides to apply the 4.5% trend for 2023 and beyond. The historical CMS funding trend over the same period has run somewhat higher, which may justify a slightly higher trend assumption than what is applied to claims in the short term, but the actuary decides to take a “wait and see” approach and use the same 4.5% trend on the CMS funding. The three-year loss ratio over the period 2020-2022 is 89.0%, which the actuary decides is sustainable, and assumes will continue in 2024 and beyond. Using the framework, the resulting trend on MA premiums is 19.3% for 2024, then 4.5% in 2025 and beyond. The 4.5% trend on MA premiums is consistent with the claims and CMS funding trend, and also reflects a constant loss ratio throughout, thereby depicting an MA plan in equilibrium.

<sup>9</sup> The authors of this practice note acknowledge that COVID-19 significantly reduced healthcare utilization and thereby the dollar amount of PMPM claims incurred in 2020 (as compared to earlier and subsequent years). This real-world outlier has been ignored in the illustrative examples used in this practice note.

### Illustration 4.3a (Shock to the System) – Initial Attempt

Setting: The setting is the same as in the previous illustration, except that the actuary has become aware of some changes in the 2024 Final Notice from CMS, which the actuary believes will dampen the CMS funding increases for 2024-2026 as the reforms are phased in over three years. The actuary estimates that the changes will reduce CMS funding by 4% over the three-year period. As an initial attempt at estimating the effects on future premiums, the actuary uses the same framework assumptions as in the previous illustration, only reduces the assumed CMS funding by 1.3% for years 2024-2026. The resulting amounts are shown below.

	Premium Guarantee								
	Known History								
	2020	2021	2022	2023	2024	2025	2026	2027	2028
(A) Paid claims	\$1,150	\$1,204	\$1,256	\$1,313	\$1,372	\$1,433	\$1,498	\$1,565	\$1,636
(B) CMS funding	\$1,175	\$1,238	\$1,302	\$1,361	\$1,404	\$1,449	\$1,495	\$1,563	\$1,633
(C) MA premium	140	100	100	100	137	161	187	196	205
(D) Total revenues	\$1,315	\$1,338	\$1,402	\$1,461	\$1,541	\$1,610	\$1,683	\$1,759	\$1,838
(E) Loss ratio = (A) / (D)	87.5%	90.0%	89.6%	89.9%	89.0%	89.0%	89.0%	89.0%	89.0%

Three-year loss ratio: 89.0%

Trend on claims paid	4.7%	4.3%
Trend on CMS funding	5.4%	5.2%
Assumed loss ratio		

Actuarial Assumptions					
4.5%	4.5%	4.5%	4.5%	4.5%	4.5%
4.5%	3.2%	3.2%	3.2%	4.5%	4.5%
N/A	89.0%	89.0%	89.0%	89.0%	89.0%

#### Resulting trend on MA premium

37.0% 17.8% 16.2% 4.5% 4.5%

The above illustration shows the leveraging effect that lowering the trend on CMS funding has on the resulting MA premiums. The MA premium was originally projected to be \$130 by 2026, as depicted in Illustration 4.2, but the reduced CMS funding trend in this illustration increases the 2026 premium to \$187. The \$187 is 44% higher than the original projection, and 87% higher than the three-year guaranteed premium for 2021-2023.

Under the circumstances, the actuary may want to consider revisiting the assumed loss ratio. As discussed previously, insurers may increase their loss ratios during times of adverse financial conditions to defray the MA premium increases for their clients. This was recently seen when the Affordable Care Act (ACA) Health Insurance Fee applied to some years and not others, yet for MA plans it affected insurer revenues by approximately \$15-\$25 PMPM. In those years, MA insurers often did not pass the full amount on to their clients in the form of MA premium increases/decreases. Instead, some chose to absorb some of that volatility, i.e. they chose to target a different loss ratio than they would have otherwise. The highly competitive marketplace for group MA includes all of the largest MA plan insurers, each of whom are taking on a significant risk while seeking significant opportunity in this marketplace. This marketplace (at least with respect to larger-sized MA groups), effectively ensures an efficient program offering going forward.

The actuary should also consider the “bargaining power” of the plan sponsor, the extent to which the plan sponsor conducts a competitive bidding process for their MA plan, and the actuary’s own knowledge of MA loss ratios for other similar-sized plan sponsors. For purposes of this illustration, suppose the plan sponsor is fairly large and has a history of selecting an MA insurer through a competitive bidding process. Also, suppose that the actuary has observed from past experience that target loss ratios as low as 90% are not uncommon for plan sponsors of this size. Armed with this knowledge, the actuary decides to discuss with the client the possibility of assuming a higher loss ratio, leading to the following illustration.

#### Illustration 4.3b (Shock to the System) – With Adjusted Loss Ratios

Setting: Given the above, the actuary and their client may conclude that an 89.0% loss ratio is too low given the headwinds on CMS funding increases from the 2024 Final Notice, and that the insurer will accept a higher loss ratio going forward rather than risk losing the business with the plan sponsor. Accordingly, the actuary decides to assume a loss ratio of 90% in 2024, increasing to 90.5% in 2025 then to 91% in 2026 and thereafter. The resulting amounts are shown below.

		Premium Guarantee								
		Known History								
		<u>2020</u>	<u>2021</u>	<u>2022</u>	<u>2023</u>	<u>2024</u>	<u>2025</u>	<u>2026</u>	<u>2027</u>	<u>2028</u>
(A)	Paid claims	\$1,150	\$1,204	\$1,256	\$1,313	\$1,372	\$1,433	\$1,498	\$1,565	\$1,636
(B)	CMS funding	\$1,175	\$1,238	\$1,302	\$1,361	\$1,404	\$1,449	\$1,495	\$1,563	\$1,633
(C)	MA premium	<u>140</u>	<u>100</u>	<u>100</u>	<u>100</u>	<u>120</u>	<u>135</u>	<u>151</u>	<u>157</u>	<u>164</u>
(D)	Total revenues	\$1,315	\$1,338	\$1,402	\$1,461	\$1,524	\$1,584	\$1,646	\$1,720	\$1,797
(E)	Loss ratio = (A) / (D)	87.5%	90.0%	89.6%	89.9%	90.0%	90.5%	91.0%	91.0%	91.0%
Three-year loss ratio:		89.0%								
		Actuarial Assumptions								
Trend on claims paid		4.7%	4.3%	4.5%	4.5%	4.5%	4.5%	4.5%	4.5%	4.5%
Trend on CMS funding		5.4%	5.2%	4.5%	3.2%	3.2%	3.2%	4.5%	4.5%	4.5%
Assumed loss ratio				N/A	90.0%	90.5%	91.0%	91.0%	91.0%	91.0%
Resulting trend on MA premium						19.9%	12.4%	11.7%	4.5%	4.5%

With the increased loss ratios, the projected 2026 MA premium is reduced from \$187 in Illustration 4.3a to \$151 in Illustration 4.3b. While this \$151 MA premium is about 16% higher than the original projection in Illustration 4.2 that excluded the 2024 Final Notice considerations, it nonetheless accounts for the CMS funding reforms in the 2024 Final Notice while still adhering to assumptions that the actuary considers to be both reasonable and realistic. The short-term projections for 2024-2026 might also help inform the actuary and the plan sponsor of what they might expect to achieve in the upcoming MA plan contract negotiations covering that three-year period.

The reader is cautioned against simply increasing the assumed loss ratio to offset adverse experience or “shocks to the system” like the CMS funding reforms. As with any other assumption used in an

OPEB valuation, the actuary should have some sort of basis or rationale to support the assumption and should be prepared to provide that support upon request in an audit. The actuary should also consider whether any such adjustments are short-term in nature (i.e., in response to a temporary shock or competitive situation) or appropriate for a long-term loss ratio target.

In the above scenario, the actuary could point to the fact that the three-year loss ratio for 2021-2023 is 89.8%, which is higher than the 89.0% for the period 2020-2022 due to the lower loss ratio in 2020. However, the rationale for further increasing the assumed loss ratio to 91.0% in the scenario largely comes from the actuary's own experience, which may not be considered sufficient support in an audit setting. An actuary may need to apply professional judgement in selecting an appropriate long-term target loss ratio that differs from recent experience or from insurer underwriting, and they should be prepared to explain the rationale for the difference.

### ***Zero-Dollar Premium Plans***

There are some group and individual market MA plans in existence today that have a zero-dollar premium.<sup>10</sup> Specifically, such plans do not require any premium for providing medical coverage to Medicare-eligible participants. As the reader may have inferred by now, these plans achieve a zero-dollar premium because the CMS funding is sufficient to cover not only the claims costs but also the administrative expenses and retention required by the insurer.

Zero-dollar premium plans pose a particular conundrum for many OPEB actuaries because the actuaries are unsure how to project the premium costs beyond the contract period. A key consideration is whether these plans are sustainable in the future at a zero-dollar premium, and if not, then how to estimate the future premium amounts. This section will address this consideration through some additional illustrations. The first will illustrate a situation where the actuary determines that the zero-dollar premium is sustainable and concludes there is no liability for the MA portion of the sponsor's OPEB benefit plan. The second will illustrate a situation where the actuary determines the zero-dollar premium is *not* sustainable and projects a non-zero premium beyond the contract period.

#### **Illustration 4.4a (Zero-Dollar MA Premium) – Initial Look**

Setting: The year is 2021, and the actuary is tasked with performing an OPEB valuation for the upcoming year end. The premium rate for the MA plan for 2020 was \$90, and the actuary has been provided with the MA plan financials for that year. However, the plan sponsor has contracted with a new insurer for their MA plan, and that insurer has guaranteed a zero-dollar premium for 2021-2023. Along with the zero-dollar premium, the new insurer has provided the actuary with their projected MA plan financials for the contract period. The new insurer has indicated that they expect to be able to provide coverage for a zero-dollar premium due to their higher star rating and superior ability to capture member health conditions (leading to higher CMS funding), as well as their superior clinical management programs, which they expect will dampen claims trend.

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<sup>10</sup> Some plans may cover medical and prescription drugs for a zero-dollar premium, but this will not be discussed further in this practice note as it is dedicated to MA-only plans.

	History	Premium Guarantee							
	2020	2021	2022	2023	2024	2025	2026	2027	2028
(A) Paid claims	\$1,100	\$1,139	\$1,184	\$1,237	\$1,293	\$1,351	\$1,412	\$1,476	\$1,542
(B) CMS funding	\$1,150	\$1,241	\$1,303	\$1,362	\$1,423	\$1,487	\$1,554	\$1,624	\$1,697
(C) MA premium	<u>90</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>
(D) Total revenues	\$1,240	\$1,241	\$1,303	\$1,362	\$1,423	\$1,487	\$1,554	\$1,624	\$1,697
(E) Loss ratio = (A) / (D)	88.7%	91.8%	90.9%	90.9%	90.9%	90.9%	90.9%	90.9%	90.9%

Three-year loss ratio:

91.2%

Trend on claims paid

Trend on CMS funding

Assumed loss ratio

Insurer Assumptions			Actuarial Assumptions				
3.5%	4.0%	4.5%	4.5%	4.5%	4.5%	4.5%	4.5%
7.9%	5.0%	4.5%	4.5%	4.5%	4.5%	4.5%	4.5%
			91.0%	91.0%	91.0%	91.0%	91.0%

In reviewing the new insurer's projected plan financials, the actuary notes that the insurer's assumed increase in CMS funding is somewhat aggressive, but the insurer seemed confident that they could achieve these levels based on their experience in transitioning existing MA plans to their platform. The actuary noted the initial claims trend was lower than usual, but did not seem overly aggressive and was willing to give the new insurer the benefit of the doubt regarding their care management programs. In addition, the insurer had indicated to the actuary and plan sponsor that they consider a 91% loss ratio to be sustainable. While the insurer does not initially project a 91% loss ratio, they indicated they are willing to accept higher loss ratios on a temporary basis (for 2021 in this case) as they transition the plan sponsor's MA enrolled population to their platform.

Accordingly, the actuary decides to accept the insurer's projections of the MA plan financials for 2021-2023. The actuary projects CMS funding and claims beyond the contract period at the actuary's default 4.5% trend, and further assumes a 91% loss ratio since the insurer indicated they consider it to be sustainable. Using these parameters, the actuary projects that the MA plan premium will remain at zero beyond the contract period, as depicted in the table above.

Note that for 2023 and after in the above illustration, the projected loss ratio is 90.9%, not 91%. This is because the actuary assumed the MA premium cannot be lower than zero. There are some arrangements where the insurer agrees to share excess profits with the plan sponsor, which can effectively bring the plan sponsor's net costs below the zero level. These excess profits ceded to the plan sponsor are known as gainshare payments, as defined in Section III. Gainshare payments are not in the scope of this scenario but will be addressed later in this Section.

#### Illustration 4.4b (Zero-Dollar MA Premium) – Later Revisit

Setting: This is the same situation as the previous illustration, only the year is now 2022 and the "new" insurer has reported on the actual plan financials for 2021. As it turns out, the plan did not perform as well as the insurer expected. The CMS funding increase from 2020 to 2021 fell far short of the 7.9% the insurer was expecting. In addition, the insurer was not able to dampen claims

increases, achieving an increase that was slightly higher than the actuary’s normal expectation of 4.5%. The actuary seeks to use this updated information to perform the next year’s OPEB valuation.

	Premium Guarantee								
	Known History								
	<u>2020</u>	<u>2021</u>	<u>2022</u>	<u>2023</u>	<u>2024</u>	<u>2025</u>	<u>2026</u>	<u>2027</u>	<u>2028</u>
(A) Paid claims	\$1,100	\$1,151	\$1,203	\$1,257	\$1,313	\$1,373	\$1,434	\$1,499	\$1,566
(B) CMS funding	\$1,150	\$1,222	\$1,279	\$1,337	\$1,397	\$1,460	\$1,526	\$1,594	\$1,666
(C) MA premium	<u>90</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>46</u>	<u>48</u>	<u>50</u>	<u>53</u>	<u>55</u>
(D) Total revenues	\$1,240	\$1,222	\$1,279	\$1,337	\$1,443	\$1,508	\$1,576	\$1,647	\$1,721
(E) Loss ratio = (A) / (D)	88.7%	94.2%	94.0%	94.0%	91.0%	91.0%	91.0%	91.0%	91.0%
Three-year loss ratio:	94.1%								
			Actuarial Assumptions						
Trend on claims paid	4.6%	4.5%	4.5%	4.5%	4.5%	4.5%	4.5%	4.5%	4.5%
Trend on CMS funding	6.3%	4.7%	4.5%	4.5%	4.5%	4.5%	4.5%	4.5%	4.5%
Assumed loss ratio		N/A	N/A	91.0%	91.0%	91.0%	91.0%	91.0%	91.0%
Resulting trend on MA premium					N/A	4.5%	4.5%	4.5%	4.5%

The actuary takes note that the MA plan performance was much worse than anticipated by the insurer. Whether the insurer was being overly optimistic, or was just simply “buying the business,” the actuary decides to abandon the insurer’s projections of claims and CMS funding increases. The insurer did demonstrate some success in driving higher CMS funding, and they had indicated that they expect somewhat higher funding in 2022 as they continue to focus on capturing the MA members’ health conditions. The actuary therefore assumes a modest 0.2% increase over the default 4.5% CMS revenue trend assumption for 2022. But otherwise, the actuary decides to project claims and CMS funding at their default of 4.5%.

The actuary notes that by using these assumptions and holding the MA premium to the zero-dollar guaranteed by the insurer through 2023, the projected three-year loss ratio for 2021-2023 is 94.1%, which is much higher than what the insurer had indicated they would accept. The actuary therefore continues to assume a 91% loss ratio beyond the contract period, holding the insurer to their word that they would consider it to be sustainable. The resulting MA premium for 2024 is \$46. Because the actuary assumes the MA plan is “in equilibrium” at this point, the \$46 premium is projected to increase at 4.5% per year. In the end, the new insurer is expected to drive lower premiums than the previous insurer, but it is largely due to the 91% loss ratio which is higher than the previous insurer was willing to accept.

Note the above two illustrations do not address the reduced trend on CMS funding for 2024-2026 resulting from the 2024 Final Notice, as the years in the setting are 2021 in the first illustration and 2022 in the second. If the actuary were to incorporate the 2024 Final Notice into the assumption set for Illustration 4.4b by reducing CMS funding trend from 4.5% to 3.2% for 2024-2026, the resulting MA

premium for 2026 would increase from \$50 to \$107. (See Illustration 4.4c in the worksheet that accompanies this practice note.) While this may seem like a large increase, recall that the MA plan's premium in 2020 was \$90, so a premium of \$107 in 2026 represents a fairly minor increase over the six-year period. As mentioned earlier in the discussion for Illustration 4.3b, the actuary may also want to revisit the 91% loss ratio assumption in light of the highly competitive group MA marketplace.

As the above illustrations show, having the details behind the plan financials – both historical and projected by the insurer – are invaluable in enabling the actuary to assess the sustainability of the zero-dollar premium arrangement and in estimating future premium levels beyond the contract period. In many situations, the actuary does not know anything other than the zero-dollar premium itself. Often times, the insurer is not asked to provide their financial projections, and the plan sponsor does not have an arrangement with the insurer that requires them to provide financial information from historical periods. Without these details, the actuary will have significant difficulties in assessing whether the zero-dollar premium arrangement is sustainable or not. Because of this, the actuary should make every effort to obtain whatever information they can regarding past plan performance and/or key assumptions behind the projections for the contract period. At a minimum, the actuary should strive to know what the loss ratios have been historically as well as what the insurer projects them to be. The issue of data sources is addressed further in Part V.

### ***MA Plans with Gainshare***

As mentioned in Section III of this practice note, and earlier in this Section, there are some MA arrangements where the insurer has agreed to share some of the excess profits with the plan sponsor, through a mechanism known as a gainshare. It is only found in group MA plans, and typically only for very large groups. An MA insurer may consider a gainshare arrangement for a very large group MA plan in situations where the plan sponsor has sufficient leverage with the MA insurer to include such an arrangement in the group MA contract.

Under these arrangements, there are generally two types of gainshare: guaranteed and conditional. MA arrangements with the plan sponsor may contain one or both of these types.

Guaranteed gainshare arrangements are typically only seen when the MA plan premium is zero and there are enough excess profits that the insurer has agreed to pay the plan sponsor a guaranteed amount on a PMPM basis. Note that a guaranteed gainshare PMPM amount does not mean the plan sponsor has a negative OPEB liability overall. In some situations, the guaranteed gainshare is held in reserve by the insurer against future MA premiums should they eventually become non-zero. In other situations, the guaranteed gainshare is to be used by the plan sponsor to offset their costs for providing prescription drug coverage (or other additional benefits) to the MA plan enrollees.

In a conditional gainshare arrangement, the gainshare amount is assessed after the end of the plan year and is typically based upon the actual loss ratio achieved in that year. For example, a conditional gainshare arrangement may be one where the insurer will share 50% of the excess profits, where excess profits are determined by any shortfall of loss ratio to 90%. Unlike with

guaranteed gainshares, conditional gainshare arrangements can be found in both zero premium and non-zero premium MA plan situations. But similar to guaranteed gainshare, conditional gainshare funds are generally to be used either to reduce MA premiums or to offset the plan sponsor's prescription drug (or other additional benefits) costs for the MA plan enrollees. The following illustration shows an MA arrangement that has both guaranteed and conditional gainshare where the MA plan is eventually assumed to be in “equilibrium” for the years after the 2024 Final Notice.

**Illustration 4.5a (Gainshare) – With 90% Assumed Loss Ratio**

Setting: It is late in the year 2023, and the actuary has been tasked with performing an OPEB valuation for the upcoming year end. The actuary has historical information from 2021 and 2022, and partial year information from the first half of 2023 regarding paid claims and CMS funding. The plan sponsor had an arrangement in 2021 where the MA premium was zero, guaranteed gainshare was \$30, and the conditional gainshare was 50% of excess profits as determined by a shortfall of loss ratio to 90%. The plan sponsor renewed their contract with the insurer for 2022-2024. Under the new arrangement, the MA premium continued to be guaranteed at the zero PMPM level, the guaranteed gainshare was increased to \$50 PMPM, and the conditional gainshare arrangement remained the same as for 2021.<sup>11</sup>

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<sup>11</sup> The contract also specifies that gainshare amounts will be payable to the plan sponsor (not held in reserve), with the understanding that they will be used to offset the plan sponsor costs for drug benefits or future non-zero MA premiums.



	Premium Guarantee								
	Known History								
	2021	2022	2023	2024	2025	2026	2027	2028	2029
(A) Paid claims	\$1,015	\$1,075	\$1,126	\$1,176	\$1,229	\$1,284	\$1,342	\$1,403	\$1,466
(B) CMS funding	\$1,220	\$1,290	\$1,353	\$1,397	\$1,441	\$1,487	\$1,554	\$1,624	\$1,697
(C) MA prem/guaranteed gainshare	(30)	(50)	(50)	(50)	(76)	(60)	(63)	(66)	(69)
(D) Preliminary net revenues	\$1,190	\$1,240	\$1,303	\$1,347	\$1,366	\$1,427	\$1,491	\$1,558	\$1,629
(E) Preliminary loss ratio = (A) / (D)	85.3%	86.7%	86.4%	87.3%	90.0%	90.0%	90.0%	90.0%	90.0%
(F) Conditional gainshare = -50% x max {90%-(E), 0} x (D)	\$ (28)	\$ (21)	\$ (24)	\$ (18)	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0
(G) Final loss ratio = (A) / [(D)+(F)]	87.3%	88.2%	88.0%	88.5%	90.0%	90.0%	90.0%	90.0%	90.0%
(H) Net Sponsor Cost = (C) + (F)	\$ (58)	\$ (71)	\$ (74)	\$ (68)	\$ (76)	\$ (60)	\$ (63)	\$ (66)	\$ (69)

		Actuarial Assumptions							
Trend on claims paid	5.9%	4.7%	4.5%	4.5%	4.5%	4.5%	4.5%	4.5%	4.5%
Trend on CMS funding	5.7%	4.9%	3.2%	3.2%	3.2%	4.5%	4.5%	4.5%	4.5%
Assumed loss ratio		N/A	N/A	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%
<b>Resulting trend on sponsor cost</b>	<b>21.6%</b>	<b>4.5%</b>	<b>-7.9%</b>	<b>11.3%</b>	<b>-20.3%</b>	<b>4.5%</b>	<b>4.5%</b>	<b>4.5%</b>	

The actuary started their analysis by estimating the 2023 paid claims and CMS funding from the partial year information provided by the insurer, which yielded a 4.7% increase in paid claims and a 4.9% increase in CMS funding over 2022 levels. Based on that information and the contractual arrangement with the insurer, the actuary determined the 2023 conditional gainshare to be \$24, which when combined with the \$50 guaranteed gainshare yielded a negative \$74 plan sponsor cost PMPM. Note that the conditional gainshare was calculated by taking half of the projected loss ratio's shortfall to 90%, then multiplying that by the insurer's preliminary net revenue (CMS funding plus MA premium and guaranteed gainshare amount).

The actuary then reviewed the actual increase in paid claims over the years 2021 to 2023. The 5.9% increase in 2022 paid claims was high, perhaps due to pandemic "catch-up." The 4.7% increase in 2023 paid claims indicated more of a return to normal levels, so the actuary chose to project future paid claims for 2024 and beyond using the actuary's default 4.5% assumption. The actuary typically would assume a 4.5% trend on the CMS funding as well, however, in consideration of the 2024 Final Notice, the actuary decided to reduce that trend to 3.2% for 2024-2026 before returning to the 4.5% assumption for CMS funding. Using these assumptions, the actuary estimated the 2024 loss ratio will be 87.3% excluding the conditional gainshare, which yields a conditional gainshare of \$18 under the contractual arrangement. This means that the resulting estimated 2024 net sponsor cost will be negative \$68 PMPM, which consists of zero MA premium, \$50 guaranteed gainshare, and \$18 conditional gainshare.

To project net sponsor costs beyond the 2022-2024 contract period, the actuary must also consider an appropriate assumption for future loss ratios. The insurer had previously indicated they would consider a 90% loss ratio to be acceptable. Additionally, the conditional gainshare has historically been set with reference to a loss ratio of 90%, which is an indication of what the insurer considers to be a threshold of excess profits. The actuary therefore decided to assume that for 2025 and later the guaranteed gainshare will be set by the insurer so as to produce a 90% loss ratio, which will in turn produce zero conditional gainshare beyond the current contract period.

The resulting trend on plan sponsor cost is shown in the last row of the table above. The sponsor cost PMPM grew from negative \$68 in 2024 to negative \$76 in 2025 (consisting entirely of guaranteed gainshare) for a sponsor cost trend of 11.3%. That relatively high increase is due to the assumption that the guaranteed gainshare will be set to produce a loss ratio of 90% rather than some lower loss ratio (where only half of the profits below the 90% threshold would be shared with the plan sponsor through the conditional gainshare). The sponsor cost then shrank to negative \$60 in 2026 for a sponsor cost trend of negative 20.3%, a result of how the 4.5% trend on paid claims is higher than the 3.2% trend on CMS funding due to the 2024 Final Notice. Sponsor cost trend beyond 2026 is simply a flat 4.5% per year, reflecting how the MA plan is in equilibrium with a constant loss ratio plus a common 4.5% trend on both paid claims and CMS funding. In this state of equilibrium, the guaranteed gainshare is also increasing at 4.5% per year, much like a positive MA premium would trend at a flat 4.5% under the same conditions.

Note that alternatively, the actuary may decide to assume the guaranteed gainshare will be set by something less than the 90% loss ratio that is used to trigger the conditional gainshare. In that case, the projections beyond 2024 will include both a guaranteed and conditional gainshare component, as detailed in the following illustration.

Also note there can be additional value from a one-sided conditional gainshare agreement that isn't reflected in the above deterministic approach. In the example above, an actuary determines that a 90% loss ratio is the appropriate long-term target loss ratio. That 90% may be reasonably predictive on average, but actual results will vary from year to year. In years where the actual loss ratio is less than 90%, conditional gainshare will be triggered. But in years where the actual loss ratio is greater than 90%, there's no adjustment and the insurer simply absorbs the worse-than-expected financial outcome. Accordingly, it is possible to have some conditional gainshare payments while still achieving a 90% loss ratio on average. Modeling this "residual" conditional gainshare is out of the scope of this practice note.

#### **Illustration 4.5b (Gainshare) – With Lower Assumed Loss Ratio**

Setting: This is the same setting as Illustration 4.5a, including the historical information through the first half of 2023, the actuary's paid claims trend assumption, and the actuary's CMS funding trend assumption. In this illustration, however, the actuary assumes the guaranteed gainshare for years starting 2025 would be set to produce a loss ratio of 88% rather than the 90% in Illustration 4.5a. The resulting amounts are shown below.

	Premium Guarantee								
	Known History		2023	2024	2025	2026	2027	2028	2029
	2021	2022							
(A) Paid claims	\$1,015	\$1,075	\$1,126	\$1,176	\$1,229	\$1,284	\$1,342	\$1,403	\$1,466
(B) CMS funding	\$1,220	\$1,290	\$1,353	\$1,397	\$1,441	\$1,487	\$1,554	\$1,624	\$1,697
(C) MA prem / guaranteed gainshare	(30)	(50)	(50)	(50)	(44)	(28)	(29)	(30)	(32)
(D) Preliminary net revenues	\$1,190	\$1,240	\$1,303	\$1,347	\$1,397	\$1,460	\$1,525	\$1,594	\$1,666
(E) Preliminary loss ratio = (A) / (D)	85.3%	86.7%	86.4%	87.3%	88.0%	88.0%	88.0%	88.0%	88.0%
(F) Conditional gainshare = -50% x max {90%-(E), 0} x (D)	\$ (28)	\$ (21)	\$ (24)	\$ (18)	\$ (14)	\$ (15)	\$ (15)	\$ (16)	\$ (17)
(G) Final loss ratio = (A) / [(D)+(F)]	87.3%	88.2%	88.0%	88.5%	88.9%	88.9%	88.9%	88.9%	88.9%
(H) Net Sponsor Cost = (C) + (F)	\$ (58)	\$ (71)	\$ (74)	\$ (68)	\$ (58)	\$ (43)	\$ (44)	\$ (46)	\$ (49)

  

Actuarial Assumptions								
Trend on claims paid	5.9%	4.7%	4.5%	4.5%	4.5%	4.5%	4.5%	4.5%
Trend on CMS funding	5.7%	4.9%	3.2%	3.2%	3.2%	4.5%	4.5%	4.5%
Assumed loss ratio (for guaranteed gainshare)		N/A	N/A	88.0%	88.0%	88.0%	88.0%	88.0%
<b>Resulting trend on sponsor cost</b>	<b>21.6%</b>	<b>4.5%</b>	<b>-7.9%</b>	<b>-13.8%</b>	<b>-27.5%</b>	<b>4.5%</b>	<b>4.5%</b>	<b>4.5%</b>

The key takeaway from the above results is that a smaller post-2024 guaranteed gainshare is produced when a loss ratio of less than 90% is assumed. For instance, the 2025 guaranteed gainshare was negative \$76 PMPM at a 90% assumed loss ratio but is now only negative \$44 PMPM at an 88% assumed loss ratio. The conditional gainshare is determined the same as it was in Illustration 4.5a, because the contractual formula that determines the conditional gainshare remains unchanged at the 90% trigger. For instance, in 2025 the conditional gainshare is  $-50\% \times (90\% - 88\%) \times \$1,397 =$  about negative \$14 PMPM. The introduction of this conditional gainshare does not fully make up for the loss of guaranteed gainshare, so that there is an overall reduction in net sponsor cost. This can also be seen by how the post-2024 final loss ratio in Illustration 4.5b is 88.9%, versus 90% in Illustration 4.5a.

### Use of Gainshare Amounts Held in Reserve

In order to finalize the per capita costs for the OPEB valuation, the actuary needs to consider the allowable use of gainshare funds under the plan sponsor's contractual arrangement with the insurer. If the gainshare amounts are to be held in reserve by the insurer and can only be used to offset future non-zero MA premiums, then the actuary would reflect a zero per capita cost for the MA plan in any such year rather than a negative per capita cost reflecting the gainshare payment. To the extent the actuary projects positive MA premiums in future years, the actuary in this case should consider reducing those projected amounts to account for any gainshare amounts currently being held in reserve by insurer, as well as any projected additional gainshare reserves due to gainshare in future years. Such a reduction in projected premiums would require an analysis of the aggregate amount of gainshare funds needed for the PMPM premium reduction.

Alternatively, if the insurer pays the gainshare each year to the plan sponsor with the stipulation that the gainshare is to be used to offset the plan sponsor's prescription drug or other benefit costs for the MA participants (as noted in Illustrations 4.5a and 4.5b), then the actuary would net the projected gainshare amounts against the projected prescription drug per capita costs to determine the combined medical and drug per capita costs in the OPEB valuation.

This situation where MA costs are essentially negative and are used to offset prescription drug costs is not that unusual, especially for very large plan sponsors. For example, a fully insured MA/PD plan premium charged by an insurer may be the net result of negative MA coverage costs offsetting positive Part D coverage costs. The actuary would not know that this is the case if the only information available is the MA/PD premium, unless the MA/PD premium is noticeably lower than what the actuary would expect for a standalone group PDP plan. There are even rare cases of a zero dollar fully insured group MA/PD premium, where the excess CMS funding on the MA side is at such a high level that it is being used to fully offset the costs on the prescription drug side.

### **Medicare Solvency and Future MA Reforms**

Many readers may be aware that the Medicare Hospital Insurance (HI) Trust Fund is facing near-term insolvency. The *2024 Medicare Trustees' Report* projects that the HI Fund will become insolvent in 2036, due to a recurring pattern of HI revenues falling short of HI program costs.<sup>12</sup>

The Overview section of the report concludes with the following statement:

*The projections in this year's report continue to demonstrate the need for timely and effective action to address Medicare's remaining financial challenges... The sooner solutions are enacted, the more flexible and gradual they can be. Moreover, the early introduction of reforms increases the time available for affected individuals and organizations—including health care providers, beneficiaries, and taxpayers—to adjust their expectations and behavior. The Board recommends that Congress and the executive branch work together expeditiously to address these challenges.*

In addition, the Medicare Payment Advisory Commission (MedPAC)<sup>13</sup> has repeatedly shared their opinion that the MA program has received excess government spending relative to traditional fee-for-service Medicare. In their January 12, 2024, status report, MedPAC estimated that MA payments will be 23% higher than fee-for-service in 2024, or \$88 billion, and attributed the excess primarily to a combination of coding intensity and favorable selection.<sup>14</sup> MedPAC has made various suggestions for alleviating the discrepancy in funding levels, which invariably would result in decreased CMS funding for MA plans, including for group MA plans.

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<sup>12</sup> The 2024 Medicare Trustees' Report can be found at <https://www.cms.gov/oact/tr/2024>.

<sup>13</sup> MedPAC is an independent, nonpartisan congressional agency established by federal law to gather information on CMS payments made to private health plans and to providers for services to Medicare enrollees, and to advise Congress based on its research.

<sup>14</sup> The latest MedPAC status report on Medicare payment policy is at <https://www.medpac.gov/document-type/report/>.

While CMS is not bound to act upon MedPAC’s suggestions, it can be argued that the 2024 Final Notice is an attempt to address some of these concerns, considering the reforms that it enacted in CMS’ risk score models and the effect these reforms are expected to have on CMS funding for MA plans. As OPEB valuation actuaries consider appropriate assumptions for projecting CMS funding into the near-term and long-term future, they may well consider whether future reforms will be enacted that further reduce CMS funding for MA plans and thereby delay the point of projected HI Fund insolvency.

Generally, anticipating specific future CMS funding reforms with respect to MA would not be appropriate in an OPEB valuation used for accounting purposes, as such a valuation should only reflect legislation and plan changes that have been enacted as of the reporting date. This would be especially true of reforms that are enacted by law, as opposed to reforms enacted by CMS alone such as the 2024 Final Notice or future regulatory changes. Ultimately, the decision of appropriateness may well depend upon the degree and nature of the anticipated reforms, as well as the auditing firm of the employer or fund’s financial statements. That being said, it is worth noting that OPEB valuations involving non-MA retiree medical benefits for Medicare-eligible participants generally have not reflected any future cutbacks of Medicare benefits, thereby implicitly assuming that the HI Fund never becomes insolvent.

## V. SOURCES OF DATA ON MA PLAN COSTS

This practice note Work Group hopes that the previous section has given the reader a better understanding of the key financial factors that drive MA plan premiums, and how to project those premiums in the future under a variety of scenarios using the framework illustrated in that section. In order to effectively use the framework, however, the actuary will need information regarding the MA plan's claims, CMS funding, and loss ratios.

One potential source for this information is a summary report from the insurer to the employer regarding the MA plan, if the insurer provides such a report. These reports are typically provided a few months after the end of each plan year and often focus on the care management aspects of the MA plan, providing information such as key claims cost drivers, comparative utilization information over the prior year, and even member satisfaction scores. While care management is often a main focus, these reports also may contain summary information relevant to the framework such as total per capita claims spend and CMS funding (which, when combined with the premium charged by the insurer will yield the loss ratio).

If the insurer does not currently provide this type of report and is unwilling to provide historical claims, CMS funding, or loss ratio information, then the actuary could discuss with the employer the possibility of requiring it of the insurer during the next renewal/marketing process. The insurer may agree to provide the information if not doing so puts the insurer at risk of losing the business. This can be particularly effective in an RFP setting, as the employer can make it a requirement within the RFP itself.

Nonetheless, many actuaries may find themselves in a situation where the information needed for the framework is not available. In that case, they will have to make an educated guess as to how the MA premiums will increase in the future, given what they know about past MA premiums and how they have changed over the years, and given what they know about future headwinds such as the 2024 Final Notice. This uncertainty is exacerbated in situations where the premium is for an MA/PD plan rather than an MA-only plan. If an MA/PD insurer is not willing to provide detailed financial information for the MA portion of the benefits, the actuary should consider asking the insurer to at least break their MA/PD premium into the MA portion of benefits versus the Part D portion. Such a premium split would allow the actuary to create a weighted average of MA and Part D trends to apply to the MA/PD premium. While the Part D weight would likely be greater than for the MA, the magnitude of that weight can vary significantly from plan to plan.

Note that obtaining an MA plan's historical financial information is only relevant to the extent that the plan experience is credible and the MA premiums are underwritten based on the specific experience of the MA plan participants. Underwriting practices will vary from insurer to insurer, but generally a group MA plan must have at least 1,000 covered lives to be considered fully credible. Just as with non-MA plans, if the group is too small to be credible, then the claims experience of the MA plan participants is pooled with that of other groups in the course of MA premium rate setting by the insurer, making the experience of the particular MA plan irrelevant for MA premium projection purposes.

Also note that obtaining an MA plan's historical financial information is only relevant to an OPEB actuary for *group* MA plans, not those on the individual market. If an actuary were interested in making detailed projections of individual market plans based on their historical experience, then he or she would likely have to track several different plans in which the employer's retirees are enrolled. Insurers of such plans would be under no obligation to report their historical information to the employer, who in turn would have much less leverage or a business case for knowing that information. Additionally, the underlying population for individual market plans is much less stable year-to-year than for group plans due to the nature of the individual market. Accordingly, the year-to-year changes in claims and/or CMS funding could vary due to changes in the underlying population in addition to the more predictable medical trend and general CMS funding increases.

Apart from the above commentary on obtaining information from the MA plan insurer, there are some external data sources that may be useful to an OPEB actuary who is trying to develop future MA premium trend projections. These sources are listed below as they exist at the time of writing this practice note, so readers are advised to check for more recently updated versions.

- [2025 CMS Final Notice](#) (released April 1, 2024)
- [Fact Sheet and FAQ on 2025 CMS Final Notice](#) (released April 1, 2024)
- [NHE Fact Sheet with the latest CMS projections](#)
- [2024 Medicare Trustees Report](#) (released May 6, 2024)

## APPENDIX A—BRIEF HISTORY OF MEDICARE ADVANTAGE (MA) AND PART D PLANS<sup>15</sup>

“Coordinated care” or managed care plans have their genesis in the “risk contract” programs first offered in 1982.<sup>16</sup> The program paid managed care organizations (primarily risk HMOs) to provide at least the same coverage as the fee-for-service Medicare plan under their managed network systems. In return, the organizations were paid a fixed amount per covered beneficiary (capitation). The fixed amount was originally intended to pay about 95% of what Medicare was paying in their service area. The capitation amount was considered a fair amount since the managed care organizations could utilize their health management techniques to control costs and utilization. And, the Medicare program would benefit from paying 95% of what it would have paid. Congress made further modifications to the program in 1985 to attract more managed care organizations.

Medicare beneficiaries began to enroll in the risk HMOs because of the lower copay requirements and richer benefits. Many HMOs provided added services such as preventive care and prescription drugs that were not provided under the Medicare fee-for-service plan. By 1997, 70% of Medicare beneficiaries lived in areas where a risk plan was available to them and 5.2 million beneficiaries (13.5% of the Medicare population) had enrolled in one of the plans.

### ***Balanced Budget Act (BBA) of 1997***

Under the BBA, Congress expanded the risk contracting program to include other types of private plans. The resulting Medicare+Choice (M+C) program allowed other organizations to offer plans under similar financial conditions as the risk contract program. These plans included preferred provider organizations (PPOs), provider service organizations (PSOs, primarily hospitals and large physician groups), private fee-for-service plans (PFFS) and medical savings accounts (MSAs). All plan offerings (except the MSAs) must provide benefits that are at least equal to the **Original Medicare** plan design, excluding hospice benefits.

The BBA also established new financing guidelines that had the effect of increasing the payment rates in rural areas and reducing the rates in urban areas. This was in an attempt to improve the access of these plans to more beneficiaries. An unintended result of this action was that because of the constraints on the payments to the existing plans in urban locations, many either cut back on the areas they served or completely abandoned some areas of the country. The result was that beneficiary access to M+C plans declined from a peak in 1998 (74% of beneficiaries had access) to a

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<sup>15</sup> Except for the final subsections on the Inflation Reduction Act and MA Plan Enrollment, this appendix is drawn from chapter three of the second edition of *Fundamentals of Retiree Group Benefits* by Dale Yamamoto.

<sup>16</sup> This appendix highlights how there have been a number of name changes for Medicare Part C, i.e. for the private insurance plans that contract with Medicare. Part C was initially referred to as “coordinated care” or “risk contract” plans, but such plans were greatly expanded by the Balanced Budget Act of 1997 and renamed as “Medicare+Choice” plans. The Medicare Modernization Act of 2003 then introduced Part D (for prescription drug coverage) and renamed Part C as “Medicare Advantage” plans.



low in 2003 (59% access). In addition, it adopted a new risk adjustment method to be implemented over five years (2000 through 2004).

Unfortunately, the refinements made by Congress under the BBA did not address the majority of service areas where plans were receiving very low increases from year-to-year (the minimum two percent per year increase) and those plans had to increase copayments, reduce covered services and increase premiums. As a result, there was a significant amount of “disenrollment” in M+C plans beginning in 2000, through 2004.

### ***Balanced Budget Refinement Act (BBRA) of 1999***

The BBRA primarily modified and refined some of the provisions enacted under the BBA. The BBRA slowed down the transition to risk adjusted costs. In addition, the law increased the payment rates for M+C plans which helped with its subsequent growth.

### ***Benefits Improvement and Protection Act (BIPA) of 2000***

The BIPA increased the minimum capitation payments to M+C plans and increased the annual percentage updates. It set the transition period for moving to risk adjustment payments from the original 5-year period set by the BBA to eight years being fully implemented by 2007.

### ***Medicare Modernization Act (MMA) of 2003***

The MMA is best known for establishing a new prescription drug program, but it also included legislation to improve plan payments and reinvigorate the managed care options. Along with it came a new name – Medicare Advantage (MA) program. The primary change to the types of plan offerings was an incentive for PPOs to offer coverage on a nationwide basis beginning in 2006.

### ***Prescription Drug Plans (Medicare Part D)***

The MMA represented the most expansive changes to the Medicare program since its inception. The biggest part of the new legislation was the addition of a prescription drug benefit to the program beginning in 2006. The plans may be stand-alone prescription drug plans (PDPs) or plans added on to a managed care plan under Medicare Advantage (MA/PD). The prescription drug benefit is a voluntary benefit under the Medicare program and is provided by private insurance companies.

The MMA specified a standard benefit design:

- \$250 annual deductible;
- Benefit of 75% of the cost of eligible drugs from the \$250 deductible up to an initial coverage limit of \$2,250;
- Beneficiaries pay the full cost of drugs from \$2,250 until they have paid \$3,600 out of their own pockets (the next \$2,850 in claims if they have no other coverage);

- After beneficiaries have paid the \$3,600 out-of-pocket, a benefit with beneficiary copays equal to the greater of \$2 for generics and preferred multiple source drugs and \$5 for all other drugs, or 5% of the cost of the drug.

All of the above dollar amounts are for 2006 and are indexed in the future based on the cost of the prescription drug program. The above is considered the minimum “standard” benefit offering that a plan must provide. Plans can be designed with other features as long as they are actuarially equivalent to this standard design. Most of the designs first offered in 2006 varied from this standard design in some fashion (e.g., lower or no deductible, higher benefit for generics, and copay design instead of coinsurance). Part D plans may also offer supplemental benefits to the standard benefit if they also offer a plan in the region that only provides the actuarial equivalent to the standard benefit.

Unlike the **Original Medicare** program, Part D plans are private plans placing independent “fixed cost bids” to cover Medicare beneficiaries.

In order to protect Medicare beneficiaries, the MMA contains a number of rules for Part D plan sponsors, including rules regarding the use of formularies, accessibility of drugs through retail pharmacies (versus mail order pharmacies), standards for electronic prescribing, and participants’ rights.

### ***Patient Protection and Affordable Care Act (PPACA or ACA) of 2010***

PPACA was passed in 2010 and made several changes to the Medicare program but most are “behind the scenes” changes that beneficiaries would not see. The key changes to coverage for Medicare beneficiaries include:

- Full coverage of annual checkups with physicians.
- Full coverage for many preventive screenings for cancer, depression, diabetes, cholesterol, obesity and other conditions.
- Freeze the threshold for income-related Medicare Part B premium for 2011 through 2019 and reduce the Medicare Part D premium subsidy for those with incomes above \$85,000 for individuals and \$170,000 for a couple.
- Elimination of the prescription drug plan “coverage gap” where no benefits were payable (e.g., between \$2,850 and \$6,455 in 2014). Brand name drugs in the coverage gap are partially paid by the participating pharmaceutical industry in the form of discounts for the drugs and the plan payment to eventually total a 75% benefit. Generic drugs are an increasing benefit percentage until 75% is reached in 2020.

Another provision that was not a direct change to Medicare but affected some retirees’ employer provided benefits was to take away the tax-favored status of a retiree drug subsidy to employers sponsoring non-Part D prescription drug benefits.

### *Inflation Reduction Act (IRA) of 2022*

The IRA includes several provisions to lower pharmacy costs for Medicare beneficiaries and to reduce drug spending by the federal government. The key provisions of the Act reduce the cost-sharing of Part D beneficiaries by:

- allowing beneficiaries to smooth their costs throughout the year,
- introducing an out-of-pocket maximum, and
- introducing a \$35 maximum insulin copay plus a \$0 vaccine copay.

From the beneficiaries' perspective, the new standard design for 2025 has a \$590 deductible with 25% coinsurance thereafter, capped by an out-of-pocket maximum of \$2,000. The deductible and out-of-pocket maximum are then annually indexed thereafter. The IRA also introduced a premium stabilization provision whereby the premium associated with the defined standard benefit is capped at 6% annual trend through 2031, where that 6% is applied on a national average basis rather than to any specific plan.

The IRA further attempts to reduce the overall program costs of Part D through three new programs:

- **Medicare Drug Price Negotiation** – This requires the secretary of the U.S. Department of Health and Human Services (HHS) to directly negotiate the price of drugs with manufacturers. Negotiations ramp up over time, starting in 2026 with ten of the top fifty Part D drugs (as ranked by aggregate spend subject to additional criteria), and increasing the number of drugs negotiated in subsequent years. Starting in 2028, Part B drugs will also be eligible to be negotiated.
- **Inflationary Rebates** – This is generally applicable to single-source brand drugs that are not subject to Medicare Drug Price negotiations. If the manufacturer of any such drug increases its price faster than inflation (Consumer Price Index for All Urban Consumers with a baseline set in 2021), then the excess of aggregate drug cost above that limit is called the Inflation Rebate and must be paid as a penalty to HHS. These penalties are then deposited into the Medicare's general Supplementary Medical Insurance Trust Fund.
- **Manufacturer Discount Program** – This replaces the Coverage Gap Discount Program that was introduced by PPACA. It requires brand drug manufacturers to pay 10% of gross costs for their products incurred before the member satisfies their out-of-pocket maximum, and 20% of gross costs thereafter. There is an exception for small and specified-small manufacturers (as defined in the IRA) which phases in this program from 2025 through 2031.

### *Medicare Advantage Plan Enrollment*

Enrollment in MA plans has fluctuated throughout the history of such plans. Much of the fluctuation could be attributed to the financing of the program. Enrollment grew steadily until the late 1990s when funding changes caused some plans to drop from the program and enrollment declined until the early 2000s. From there, enrollment rose rapidly and slowed in the 2010s, but has steadily grown since then to cover 54% of Medicare beneficiaries by 2024. Note that the majority of MA enrollees are individual plan participants. E.g., the 33 million MA program enrollees as of January 2024 were split as 62% individual, 20% special needs, and 18% group.<sup>17</sup>

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<sup>17</sup> More detail on the rise in Medicare Advantage enrollment can be found at <https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2024-enrollment-update-and-key-trends/>.

## APPENDIX B—COMMON TERMS

The following terms are used in this practice note without bold font.

*MA Plan* – Medicare Advantage plan, otherwise known as Medicare Part C. For those who enroll in an MA Plan, such plan replaces their Medicare Parts A & B coverage. There are two general types:

- Individual MA Plan: A fully insured MA Plan offered on the individual market.
- Group MA Plan: A fully insured MA Plan offered to a specific group of retirees. Typically, the plan sponsor is an employer, union, or multi-employer trust fund.

*Part D Plan* – Medicare Part D prescription drug plan. There are two general types:

- Individual Part D Plan: A fully insured Part D plan offered on the individual market. This is also called a “PDP” if it is offered on a stand-alone basis (i.e., without an MA plan).
- Group Part D Plan: A fully insured or self-funded Part D plan offered to a specific group of retirees. Typically, the plan sponsor is an employer, union, or multi-employer trust fund.

*MA/PD Plan* – An individual or group plan that includes both Medicare Advantage and Medicare Part D coverage.

*EGWP* – Acronym for “Employer Group Waiver Plan.” This is a generic term that can refer to a Group MA, Group Part D, or Group MA/PD plan.

## APPENDIX C—TREND FOR PAID CLAIMS VERSUS CMS FUNDING

In the framework illustrations throughout Part IV of this practice note, it is assumed that in the long-term the year-to-year increases in CMS funding will keep pace with the increases in claims. This view was also shared by representatives from the Office of the Actuary (OACT) at CMS when they were interviewed by the Work Group. However, their comments were directed primarily towards funding increases in the overall MA market, not specifically for the group market.

Some actuaries believe that for group MA plans in particular, CMS funding increases will lag behind those of paid claims on a long-term basis. Other actuaries do not share this view. This appendix presents the main arguments for and against a long-term difference.

### *Cost Control Differences*

In considering why CMS funding increases may lag behind the paid claims increases for group MA plans (but not for individual market plans), one argument is related to how group versus individual plans control claims costs. Individual market MA plans tend to be network-based HMOs and benefit-differential PPOs, which feature explicit differences in cost-sharing for network versus non-network utilization. Typically, individual MA plans also have certain cost-reduction features such as lean plan designs to control utilization, locally optimized networks, and compulsory care management. Group MA plans, in contrast, tend to be “passive” PPOs where there is no benefit differential between in-network and non-network utilization, and they typically reflect richer benefit designs than individual market plans. The argument is that because of these differences, individual market plans will control claims costs better than group plans, and will therefore have lower claims trends in the long run.

On the other hand, group MA plans are typically more actively managed than individual plans. Group MA insurers will tend to invest more resources into ongoing case and care management, and such management will tend to be more effective because of the longer-term relationship with the more stable populations typically inherent in group MA plans.

So, while the dollar amount of per-capita claims may be lower for individual than group MA plans due to leaner benefit designs and tighter network requirements, there is a question as to whether such measures will be able to dampen claims trend more effectively than the more actively managed group MA market on a long-term basis. That said, claims trends in the short-term may well differ between the group and individual MA markets. This underscores the importance of gathering as much information as possible from MA carriers and performing trend analyses such as those outlined in this Practice Note.

### ***Competitive Pressure Differences***

Another argument for CMS funding increases lagging behind claims increases on a long-term basis for group MA plans pertains to the fact that since 2018, only individual market plans submit bids to CMS and not group plans. Each year, CMS publishes county-level benchmarks based on fee-for-service Medicare Parts A and B costs, and individual market plans receive additional CMS funding to the extent their bids are below those benchmarks. Group plans, in contrast, receive CMS funding based on the average individual market bids relative to the benchmarks, with a one-year lag. This was mentioned earlier in this practice note under “CMS Medicare Advantage Funding” in Part III. The argument is that individual plan bid-to-benchmark ratios have steadily decreased over time as driven by the competitiveness of the individual market, which then creates a financial “headwind” for group plans as they struggle to keep pace with these declining ratios.

A counter to this argument is to note that group plans should have experienced lower increases in CMS funding than in paid claims since 2018, which should have in turn driven group MA plan premium increases that far outpace medical inflation. However, it has been the experience of many of the Work Group members, and some of the peer reviewers of this practice note, that group MA plan premium increases have generally not outpaced medical inflation since 2018, and in fact in many cases the premiums have remained flat or decreased (at least until the CMS funding reforms took place in 2024). Further, some actuaries note that the pattern of decreasing bid-to-benchmark ratios cannot continue indefinitely, as there is only so much that can be accomplished through increasing cost-sharing and tightening networks.

### ***Short-Term Versus Long-Term Differences***

As the years unfold, it will be interesting to see whether the individual market-driven bid-to-benchmark ratios continue their decline, and whether group MA plan premiums continue to increase at a pace higher than that of paid claims beyond the 2024-2026 phase-in period of the CMS funding reforms. Due in part for the sake of simplicity, this practice note does not reflect this potential short-term difference in CMS funding versus paid claims increases into our framework illustrations.

However, the MA market plays out over the next several years, OPEB actuaries need to address assumptions on a long-term basis. It is important to consider whether it is appropriate to assume short-term phenomena are sustainable on a long-term basis. Some actuaries would argue that significant differences sustained on a long-term basis for group MA plans would cause the plan premiums to eventually increase to unsustainably high levels, effectively leading to the eventual demise of the group MA market. Ultimately, the decision of what long-term differences to assume, if any, rests with the actuary and their client.

## APPENDIX D—REFINED FRAMEWORK ILLUSTRATION

Detailed in this appendix is a more refined framework illustration than the usual one presented throughout this practice note. Under this refined framework, explicit amounts for administrative expenses and insurer profits are reflected. All of these components fit together using the following formula: **[paid claims] + [administrative expenses] + [profit] = [CMS funding] + [MA premium]**. Note that loss ratio no longer directly comes into play, as the measure of the insurer's profitability is now the explicit profit amount.

### Illustration with Administrative Expenses

Setting: The setting for this illustration is the same as for Illustration 4.2, where the insurer has reported actual 2020-2022 financial information (which now includes administrative expenses), the MA premium was \$140 in 2020 then guaranteed at \$100 for 2021-2023, and the actuary seeks to project the MA premium beyond the contract period for an OPEB valuation. The insurer did not provide their historical profit levels for 2020-2022, but profit in those years can be determined from the other four components using the formula provided at the beginning of this appendix:  $\text{profit} = [\text{CMS funding} + \text{MA premium}] - [\text{paid claims} + \text{administrative expenses}]$ . From these components, the actuary can then determine the total revenues, loss ratio (if it is still desired for informational purposes), and profit as a percentage of revenue. The latter is also known as “profit margin” and is equal to  $[\text{profit}] / [\text{CMS funding} + \text{MA premium}]$ , which is equivalent to  $1 - \{[\text{paid claims} + \text{administrative expenses}] / [\text{CMS funding} + \text{MA premium}]\}$ .

The actuary applies the same 4.5% trend assumption to the paid claims and CMS funding as in Illustration 4.2, but in order to determine the MA premiums, the actuary must also have a method for projecting administrative expenses and profit. Projecting administrative expenses is nothing new to health actuaries, so the actuary applies a flat 3.0% trend to that component, roughly pegging it to a long-term Consumer Price Index (CPI) assumption. To estimate profit in future years, the actuary utilizes an assumption that profit margin will remain constant, and sets it equal to the 6.8% three-year profit margin for 2020-2022. The MA premium after 2023 is then determined by the following formula:  $\{[\text{paid claims} + \text{administrative expenses}] / [1 - \text{assumed profit margin}]\} - [\text{CMS funding}]$ .

The resulting projections are as shown below, where the dollar amount of profit is displayed even though it is not needed in the calculation of MA premium (which instead relies on the assumed profit margin). It is also not necessary to determine loss ratios after 2023, but they are displayed to illustrate how the loss ratios increase slightly over time due to the underlying assumptions.



		Premium Guarantee								
		Known History								
		<u>2020</u>	<u>2021</u>	<u>2022</u>	<u>2023</u>	<u>2024</u>	<u>2025</u>	<u>2026</u>	<u>2027</u>	<u>2028</u>
(A.1)	Paid claims	\$1,150	\$1,204	\$1,256	\$1,313	\$1,372	\$1,433	\$1,498	\$1,565	\$1,636
(A.2)	Admin expenses	<u>55</u>	<u>56</u>	<u>57</u>	<u>59</u>	<u>60</u>	<u>62</u>	<u>64</u>	<u>66</u>	<u>68</u>
(A.3)	Paid claims plus admin	\$1,205	\$1,260	\$1,313	\$1,371	\$1,432	\$1,496	\$1,562	\$1,631	\$1,704
(B)	CMS funding	\$1,175	\$1,238	\$1,302	\$1,361	\$1,422	\$1,486	\$1,553	\$1,623	\$1,696
(C)	MA premium	<u>140</u>	<u>100</u>	<u>100</u>	<u>100</u>	<u>115</u>	<u>119</u>	<u>123</u>	<u>128</u>	<u>132</u>
(D)	Total revenues	\$1,315	\$1,338	\$1,402	\$1,461	\$1,537	\$1,605	1,676	\$1,750	\$1,828
(E)	Profit = (D) – (A.3)	\$ 110	\$ 78	\$ 89	\$ 89	\$ 104	\$ 109	\$ 114	\$ 119	\$ 124
(F)	Loss ratio = (A.1) / (D)	87.5%	90.0%	89.6%	89.9%	89.3%	89.3%	89.4%	89.4%	89.5%
	Three-year loss ratio:	89.0%								
(E)	Profit margin = (E) / (D)	8.4%	5.8%	6.3%	6.1%	6.8%	6.8%	6.8%	6.8%	6.8%
	Three-year profit margin:	6.8%								
		Actuarial Assumptions								
	Trend on claims paid	4.7%	4.3%	4.5%	4.5%	4.5%	4.5%	4.5%	4.5%	4.5%
	Trend on administrative expenses	1.8%	1.8%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%
	Trend on CMS funding	5.4%	5.2%	4.5%	4.5%	4.5%	4.5%	4.5%	4.5%	4.5%
	Assumed profit margin			N/A	6.8%	6.8%	6.8%	6.8%	6.8%	6.8%
Resulting trend on MA premium						14.7%	3.7%	3.7%	3.7%	3.7%

As can be seen above, this framework yields projected MA premiums that are lower than under this practice note’s usual illustrated framework. For example, by 2028 the MA premium here is projected to be \$132, as compared to \$142 under Illustration 4.2 with the usual framework.

Central to this framework is the assumption that the insurer’s profit margin will be constant over time. This replaces the usual framework’s assumption that it is the loss ratio which will remain constant. An assumption of constant profit margin on a long-term basis would be considered reasonable by most actuaries, as it could be needed for long-term sustainability. Earlier comments throughout this practice note on loss ratios are translatable to profit margins, as high/low loss ratios correspond to lower/higher profit margins. Lower profit margins will tend to be seen for larger employers, particularly those that make a practice of marketing their MA plan on a regular basis. MA plans with relatively low enrollment will tend to see higher profit margins, due in part to a lack of “leverage” by the plan sponsor, and in part to the unpredictability of claims levels/pooling of claims associated with smaller enrollment. Generally speaking, profit margins tend to be in the 3%-12% range for group MA plans.

Administrative expenses for MA plans are similar to that for other health plans. They of course will vary by insurer, but generally speaking they fall within a range of \$50-\$90 on a PMPM basis in 2024. Large national insurers will tend to have lower administrative expenses than smaller regional

insurers. Under this framework, assuming that administrative expenses increase at a slower rate than both paid claims and CMS funding will ensure that MA premiums also increase slower (while loss ratios gradually creep upward). Even though this is different than the results shown in the other illustrations of this practice note for the years when the MA market is projected to be in equilibrium, it is no less valid (and arguably more accurate) if one views assumptions on administrative expense increases and profit margins to be more reliable or accessible than assumptions on future loss ratios.

This framework can of course be applied to the other illustrations in this practice note as well, and will generally tend to project lower MA premiums over time than the usual framework, as long as (1) the trend on administrative expenses is less than that applied to claims and CMS funding, and (2) the profit margin is assumed to be held constant in the long-run.

Also note that under this refined framework, the resulting trend on MA premiums will vary by setting even though the underlying assumptions are the same as illustrated above. For example, if the same assumptions (6.8% profit margin, 3.0% admin trend, 4.5% claims trend, and 4.5% CMS funding trend) are applied using this refined framework to the setting of illustration 4.1, then the resulting trend on MA premiums is 2.7% instead of the 3.7% shown above.