

# Study of the impact of introducing a maximum out-of-pocket limit on Part D drugs for beneficiaries enrolled in MA-PD plans

Eliminating the 5% coinsurance in the Part D catastrophic phase for certain MA-PD beneficiaries

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Medicare Advantage Prescription Drug (MA-PD) plans<sup>1</sup> are required to provide annual maximum out-of-pocket (MOOP) limits on beneficiary cost sharing for medical services covered under Medicare Parts A and B. By contrast, there is no such MOOP limit for pharmacy benefits covered under Part D. At the request of Pfizer, we modeled the impact of applying a Part D plan MOOP to MA-PD plans as a supplemental benefit funded through supplemental Part D premiums.

MA-PD beneficiaries who do not qualify for the Part D low-income subsidy (known as “non-LIS” beneficiaries) pay the greater of 5% of the drug cost or a copay (\$3.70 for generics and \$9.20 for brands) after reaching the catastrophic threshold or true out-of-pocket (TrOOP) limit (\$6,550 in 2021, or about \$10,000 in total annual drug cost). The current Part D benefit design exposes non-LIS beneficiaries to unlimited cost sharing because there is no MOOP limit for the Part D benefit under MA-PD plans. Eliminating patient cost sharing in the catastrophic phase was a central element of the Trump Administration Blueprint<sup>2</sup> and has been included in recent Part D reform proposals.<sup>3,4</sup> This paper examines how a Part D MOOP limit might impact MA-PD plans, including:

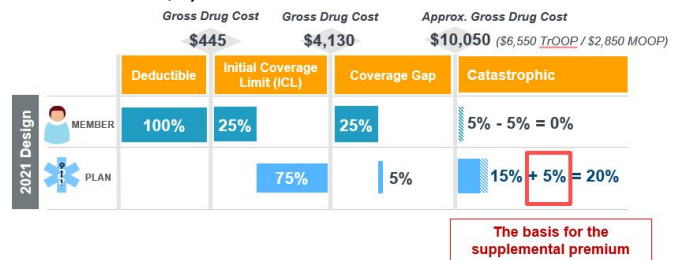
1. The supplemental premium that would be required to fund a Part D MOOP on MA-PD plans.

2. Potential ways for MA-PD plans to mitigate the effects of the additional premium.
3. How the Part D MOOP could be implemented in today’s MA-PD market.

Our analysis is limited to the Part D benefit for MA-PD plans; it does not consider standalone Part D plans (PDPs). We estimated the MA-PD Part D supplemental premium if a MOOP of \$2,850 were established as part of enhanced alternative benefits.<sup>5</sup> This amount is approximately equivalent to the 2021 effective beneficiary cost sharing for non-LIS beneficiaries at the time of entering the catastrophic phase of Part D, net of manufacturer coverage gap discounts. We explored two scenarios of Part D MOOP implementation for MA-PDs: 1) Part D MOOP applies only to non-LIS beneficiaries, and 2) Part D MOOP applies to all MA-PD beneficiaries.

## Supplemental premiums to fund an MA-PD pharmacy MOOP

Figure 1: Illustrative 2021 Enhanced Alternative (EA) Benefits with a \$2,850 Part D MOOP



<sup>1</sup> A Medicare Advantage Prescription Drug (MA-PD) plan is a private Medicare plan that includes Part A, Part B, and prescription drug coverage.  
<sup>2</sup> The U.S. Department of Health and Human Services. May 2018. American Patients First The Trump Administration Blueprint to Lower Drug Prices and Reduce Out-of-Pocket Costs. Retrieved February 27, 2020, from <https://www.hhs.gov/sites/default/files/AmericanPatientsFirst.pdf>.  
<sup>3</sup> The House Bill (9/19/2019), Lower Drug Costs Now Act of 2019. Retrieved February 27, 2020, from <https://www.congress.gov/bill/116th-congress/house-bill/3>  
<sup>4</sup> Senate Finance Committee (7/25/2019). The Prescription Drug Pricing Reduction Act (PDPRA) of 2019. Retrieved February 27, 2020, from <https://www.finance.senate.gov/imo/media/doc/FINAL%20Description%20of%20the%20Chairman's%20Mark%20for%20the%20Prescription%20Drug%20Pricing%20Reduction%20Act%20of%202019.pdf>  
<sup>5</sup> "Enhanced alternative" is a type of alternative Part D benefit that requires a supplemental premium and includes (1) basic prescription drug coverage, and (2) supplemental coverage.

Figure 1 illustrates an enhanced Part D benefit in the catastrophic phase with a \$2,850 MOOP. We estimate that implementing a Part D MOOP on non-LIS beneficiaries would result in a supplemental Part D premium increase<sup>6</sup> of \$3.50 per member per month (PMPM) in 2021. If all MA-PD beneficiaries received the MOOP, the supplemental premium would increase to \$5.80 PMPM. The second option results in a higher premium due to inclusion of LIS beneficiaries, who are more likely to reach the catastrophic phase. The supplemental premium for the Part D MOOP has two components:

- A shift of dollars from beneficiaries (or cost-sharing subsidies for LIS) to MA-PD plans, as the 5% cost sharing in catastrophic is absorbed by the plan.
- Induced utilization, as beneficiaries no longer pay cost sharing after reaching the MOOP, thus removing a financial disincentive to fill their scripts.<sup>7</sup>

## Impact on federal government costs

Adding a Part D MOOP will impact federal government spending on Medicare. For every \$1.00 PMPM spent in the Part D catastrophic phase, the government subsidizes \$0.80 PMPM through federal reinsurance for all beneficiaries, plus \$0.05 PMPM for LIS beneficiaries through cost sharing subsidies. We estimate that, if the Part D MOOP applied only to non-LIS beneficiaries, induced utilization would increase federal reinsurance spending by \$3.25 per non-LIS beneficiary per month, or \$500 million per year, after accounting for the government's share of prescription drug rebates. However, if the MOOP applied to all beneficiaries, the impact to the government would be a net savings of \$200 million, as the government would no longer pay for cost-sharing subsidies for LIS beneficiaries in the catastrophic phase, offsetting increases in federal reinsurance spending.

## Impact on beneficiary premiums

Usually, benefit enhancements increase plan costs, driving up beneficiary premiums. However, some MA-PD plans may elect to absorb the additional premium, as beneficiaries are sensitive to premium increases. MA-PDs may handle the cost of the

additional Part D supplemental premium differently depending on their market positioning.

Zero-premium plans, which account for over half of all MA-PD enrollment,<sup>8</sup> are likely to prefer to introduce changes to their benefit offering to avoid charging a beneficiary premium and retain market share.<sup>9</sup> This is because MA-PD plans have flexibility in the allocation of "MA rebates"<sup>10</sup> (extra revenue that certain plans receive based on costs and quality measures).

These MA rebates fund supplemental benefits like vision, hearing, dental, and over the counter medicines (OTC).<sup>11</sup> A typical MA-PD plan may allocate their MA rebates as follows:

**Figure 2: Illustrative MA Rebate Allocation Before Part D MOOP**

SUPPLEMENTAL BENEFITS	MA REBATE ALLOCATED (\$PMPM) <sup>12</sup>
Reduction in A/B cost sharing	\$60
Part D Premium Buy-down	\$35
Non-Medicare Covered Supplemental Benefits	\$25
<b>Total</b>	<b>\$120</b>
<i>Options to allocate \$25 MA Rebate in Non-Medicare Supplemental Benefits may include:</i>	
<i>Dental</i>	\$8
<i>Vision</i>	\$4
<i>Hearing</i>	\$2
<i>OTC</i>	\$10
<i>Transportation</i>	\$5
<i>Health &amp; Education</i>	\$3
<i>Acupuncture</i>	\$2

Zero-premium MA-PD plans may elect to fund the Part D MOOP benefit by reallocating some of the rebate dollars that would otherwise be used for other supplemental benefits. On the other hand, non-\$0 premium MA-PD plans, which on average carry a monthly premium of just over \$60, may be able to pass all or some of the additional supplemental premium onto the beneficiaries.

<sup>6</sup> Most beneficiaries enrolled in MA-PDs already have enhanced alternative benefits that carry a supplemental Part D premium. Although many plans "buy down" this premium on behalf of beneficiaries. Our estimates reflect only the portion of premium attributable to the implementation of the MOOP.

<sup>7</sup> Because most LIS beneficiaries pay no cost sharing after TrOOP, we have assumed no change in LIS beneficiary behavior due to the MOOP.

<sup>8</sup> Excluding beneficiaries in SNPs, employer-sponsored group plans, demonstrations, Health Care Prepayment Plans (HCPPs), Program of All-Inclusive Care for the Elderly (PACE) plans, and plans for special populations

<sup>9</sup> Jacobson, G., Damico, A., & Neuman T. (November 13, 2018). A Dozen Facts About Medicare Advantage. Kaiser Family Foundation. Retrieved February 19, 2020, from <https://www.kff.org/medicare/issue-brief/a-dozen-facts-about-medicare-advantage/>.

<sup>10</sup> MA rebates are calculated as a percentage (determined by the MA-PD quality star rating) of the difference between a plan's "bid" (the MA-PD's cost estimate for providing fee-for-service benefits plus expenses and margin) and the risk-adjusted fee-for-service benchmark. CMS rules require MA-PD plans to spend all MA rebates to fund supplemental benefits or to reduce premiums.

<sup>11</sup> Barnhart, A. February 24, 2020. An Analysis of supplemental benefit prevalence in Medicare Advantage plans. Available at [https://milliman-cdn.azureedge.net/-/media/milliman/pdfs/articles/an\\_analysis\\_of\\_supplemental\\_benefit\\_prevalence\\_in\\_medicare\\_advantage\\_plans.ashx](https://milliman-cdn.azureedge.net/-/media/milliman/pdfs/articles/an_analysis_of_supplemental_benefit_prevalence_in_medicare_advantage_plans.ashx)

<sup>12</sup> Values for illustrative purpose only

Below are some options for MA-PD plans to absorb the additional supplemental premium, which may work alone or in combination:

- Reallocate some of the MA rebates used for other supplemental benefits
- Restrict drug formularies to negotiate higher Part D rebates from manufacturers, implement a preferred pharmacy network to obtain pharmacy rebates, or encourage higher use of generics<sup>13</sup>
- Decrease margins (subject to bid requirements)

**Figure 3: Financing of MA-PD Plans**

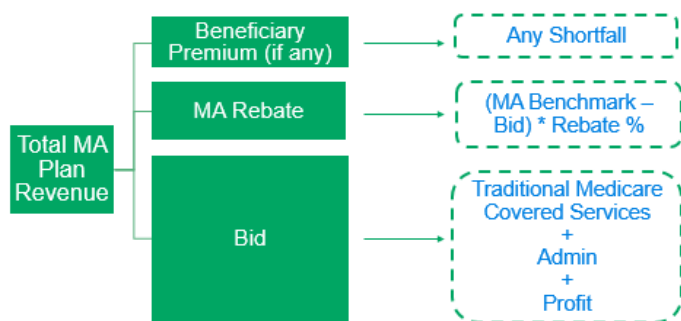


Figure 3 illustrates the financing of MA-PD plans, where plan sponsors receive plan revenue from their bids, MA rebates, and beneficiary premiums to cover claims, administrative costs, and margin.

## Implementation considerations for a pharmacy MOOP in MA-PDs

The implementation of a Part D MOOP presents several regulatory challenges to the Centers for Medicare and Medicaid Services (CMS). In particular, determining the population affected, whether the MOOP is mandatory or optional, and the impact to the Part D market as a whole are key considerations for pricing the MOOP benefit.

Deciding the segment of Part D beneficiaries to which the MOOP applies is key. Should the MOOP apply to LIS beneficiaries, beneficiaries enrolled in dual-eligible special needs plans (D-SNPs), or employer group waiver plans (EGWPs)? Non-LIS beneficiaries have a much greater need for a MOOP than LIS beneficiaries, as fully subsidized LIS beneficiaries (including beneficiaries in D-SNPs) have zero cost sharing in the catastrophic phase. Many LIS beneficiaries choose to enroll in \$0 premium plans; therefore, the supplemental premium needed to fund the MOOP will vary from plan to plan based on the LIS/non-LIS enrollment mix. Excluding beneficiaries in D-SNP plans, who

are unlikely to benefit from the Part D MOOP, can reduce the supplemental premium impact to plans.<sup>14</sup> Similarly, many EGWP plans offer benefits that are substantially richer than defined standard Part D, and thus may benefit less from a MOOP.

We assumed in this report CMS would establish a mandatory pharmacy MOOP requirement for MA-PD plans. We believe it is unlikely MA-PDs would voluntarily offer a Part D MOOP because that could result in adverse selection due to a disproportionate share of beneficiaries with catastrophic spending enrolling in plans with a MOOP. In that case, the Part D supplemental premium could be substantially higher than the estimates shown here. We also assumed the Part D MOOP would be mandatory for the MA-PD market but not required for the standalone PDP market. PDP members have Medicare fee-for-service (FFS) coverage without a MOOP for Parts A and B. While a Part D MOOP may entice beneficiaries with high Part D spending to move from FFS to MA-PD, some beneficiaries in FFS may be discouraged by MA-PD provider networks, and those with subsidized retiree medical benefits or EGWP coverage would see little reason to move to an individual MA-PD plan with a MOOP.

Another consideration in implementing a Part D MOOP would be minimizing the disruption to the broader PDP market. A mandatory Part D MOOP in the form of enhanced Part D benefits does not interfere with the Part D defined standard benefit. That is, the defined standard Part D benefit would not be altered. MA-PDs would continue to estimate costs under the defined standard benefit design, with 5% coinsurance in the catastrophic phase, as part of their annual bid submission to the CMS. This would ensure that the methodology for calculating the national average bid amount (NABA) and national average member premium (NAMP), which in turn dictate government subsidies in Part D, remains unchanged.

## Methodology and data sources

We used a random sample of thousands of non-LIS and LIS beneficiaries from Milliman's 2018 Prescription Drug Consolidated Database (PDCD) to model the impact of a Part D MOOP on MA-PD beneficiaries. We calibrated our data and models to the 2020 national average monthly bid amount and national average base beneficiary premium. We determined the financial responsibility of the government, Part D beneficiaries, plans, and pharmaceutical manufacturers if MA-PD plans implemented a Part D MOOP. To assess the range of resulting Part D supplemental premiums, we estimated the impact of the MOOP under two implementation scenarios: 1) non-LIS

<sup>13</sup> This option may reduce both basic and supplemental Part D premiums, therefore freeing up more MA rebates to fund the MOOP benefit.

<sup>14</sup> D-SNP plans account for about 49% of LIS enrollment in MA-PDs.

beneficiaries only, and 2) both non-LIS and LIS beneficiaries. The impact on federal spending was estimated using enrollment from the 2018 Trustees Report.<sup>15</sup>

We excluded EGWPs from our analysis as they do not submit bids to CMS and receive subsidies linked to the individual market. Because we anticipate no change in the Part D direct subsidy from the MA-PD MOOP, this enhancement would have no impact on EGWP plans.

## Caveats and limitations

This report was commissioned by Pfizer, Inc., a pharmaceutical drug manufacturer. The findings reflect the research of the authors. Milliman does not endorse any product or organization. Estimates in this report represent national averages. Differences between our projections and actual amounts depend on the extent to which future experience conforms to the assumptions made for this analysis. For any particular plan, results may vary substantially due to enrollment mix, formulary, and benefit design, among other factors.

Gabriela Dieguez, Amy Kwong, and Stephanie Hill are members of the American Academy of Actuaries and meet the qualification standards for performing the analyses in this report and rendering the actuarial opinions contained herein.

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<sup>15</sup> 2018 Trustees Report. Available at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2015.pdf>

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